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PASSIM

THE principal object of the *Gazette*, according to the declaration of the editorial committee when the first number was published some seventy odd years ago, was that it should serve as a " medium between one class of Guy's men and another," and that it should provide an account of " everything of interest that passes " at the Hospital. No claim is made that this ambitious standard has ever been properly attained. Nevertheless, if for no other reason than to follow the noble lead given by the founders of this journal it is the intention to give in this number at least some account of how Christmas, 1948, was celebrated at Guy's.

What proved to be the inaugural episode of the season was without doubt unintentional. Some of the more enthusiastic of the sporting fraternity, returning one supposes from refreshment at the Anchor, must have resolved upon that time-honoured custom of towing the dray from the Bankside brewery to the College. Whether their energies flagged in St. Thomas's Street, or whether the residential proximity of a respected member of the staff of great surgical and rugger prowess overcame them is not at all clear. At any rate, a digression was suffered with calamitous consequences to the railings guarding the area between the *Gazette Office* and No. 4. Though the offending vehicle was rescued with exemplary promptness the shattered railings remain as testimony to the occasion.

There next took place those excursions probably more appropriate to the season and certainly of more devout import. We refer, of course, to the carol-singing which, interestingly enough, took an almost reciprocal form. While a party of singers from the B.B.C. toured the wards on the evening of 20th December a brave band from Guy's faced the rigours of the elements, in all their forms, to give voice in Trafalgar Square. The visitors from Portland Place came for the first time. Their renderings were appreciated and enjoyed on all sides and it is hoped that this initial venture, organised largely by the brother of an old Guy's man, will set a precedent for further visits in years to come

The Guy's stalwarts invading the West End, however, were maintaining a practice first started in 1944. Then it was that £20 were raised in Leicester Square for the Red Cross Prisoner-of-War Fund. In 1946, £60 were collected in the same district for a children's party and the following year no less than £110 were amassed to provide entertainment and presents for the patients in Caleb and Diplock wards over Christmas. This year, 1948, a new problem presented itself. No longer could the Hospital be regarded as a charitable institution and the Governors were compelled to withhold permission for any collections to be made under their name. But by the courtesy of the Provost of Southwark Cathedral the venture was allowed in aid of the Southwark Children's Fund. A further series of negotiations followed with the various powers concerned, from Scotland Yard to the Ministry of Works and, after much perseverance, the other essential approvals were obtained. At five hours' notice five bandsmen were enrolled from the Middlesex Regiment by the agreement of the officer commanding. Red lamps were procured from Bermondsey Borough Council and the various other impedimenta proper to such a procession—poles, banners, carol sheets and cough lozenges, were collected together. Eventually a posse some seventy strong, comprising nurses, students, physiotherapists and others, moved off from the colonnade and by way of London Bridge and Charing Cross reached Trafalgar Square. There the crowds

were overflowing. A little difference with the police had to be settled over precisely what constituted a "procession." Then, as the leonine plinths were out-of-bounds, the steps of St. Martin's served as choir stalls. With recital concluded, bodies cold and throats dry, adjournment followed to the nearby Corner House. What better could be done than to sing for the coffee therein! But the management was adamant. The premises, they insisted, were not licensed for song and the other patrons were consequently denied this extra entertainment. In the end the collection boxes yielded close on £65, a valuable contribution to the "party" funds.

Not that this represented all the carolling on Christmas Eve. The wards were treated to the further pleasure of music by the Southwark Cathedral choir.

And of the wards themselves? Seldom could more imagination, art and industry have gone into their decoration. To single out any for special mention verges on the invidious, such was the excellence throughout. Adequate description, too, is impossible. Yet record must be made of Lydia village, with each bed a dwelling; of Davy Jones' Locker, complete with Neptune, in Luke; of the rugger match in Christopher, with its goal-posts, stands, ball and, it is said, even patients in jerseys; of the Alician wonderland of Diplock; of the historical sequences of Patience and Samaritan; of the Stork Club (members only) in Victoria nursery and of the topical Theatre Agency in Nuffield.

Gone are the days of the nigger minstrels. Maybe their revival would invite unfortunate comparison. Nevertheless, some of the residents did put on a show of their own. If they lacked in histrionic ability their spontaneity and incongruity well made up for it and, at the second presentation, the unrehearsed scene with one of the players in the sparsest of infant attire crashing through the top of the trolley upon which he was riding obviously met with the full approval of the audience!

There were, as well, the regular features. The Salomon's Centre party for the infants and mothers was held this year in the Chapter House of the Cathedral. To the accompaniment of piano and youthfully manipulated accordions the most precocious of youngsters displayed themselves in tap and acrobatic with an immensity of verve and assurance that went well with their "Windmill" costume. And each guest at the end received a handsome present.

The Landon tea-party for the out-patient children of the past twelve months was somewhat restricted by lack of space since X-ray encroached upon the erstwhile spacious hall. Still, two hundred or more youngsters squeezed in to sing, dance, take tea, assist Punch and Judy with much vociferous advice and marvel at the stunts of the three clowns who, between performances at Olympia and entirely without financial reward, now arrive each year to do their show at Guy's. Here again, toys, oranges and nuts were dispensed before leaving, this time by a jovial if rather pædiatric Santa Claus. Finally, but by no means least, came the conjurer-ventriloquist who demonstrated his legerdemain in Caleb-Diplock on Boxing afternoon before the visitors' tea. No one watching will ever forget the looks of dismay on the faces of his two volunteer assistants as they found, after chewing small pieces of paper together for some minutes, that all they could recover was a pappy mass whereas their mentor contrived to extract yard upon yard of coloured streamer!

Credit is due also to the catering department. To the quantity, variety and gaiety of the food there was no limit. A good feed, in fact, was had by all, patients, staff and visitors alike.

And what else happened at Christmas? Well, many things; some, we are sure, that should be reported but of which we know nothing—forgive us our omissions, and others of which we may have seen and heard yet do not write, if only for personal or intimate reasons! There were the streamers from the College windows, the sign-board in the Park which pointed to the Medical School and bore the ominous word "Gravesend" and the resident who was seen on all fours barking at a very condescending but real dog. These, however, were incidentals. There may have been no more than three-quarters of the usual complement of patients in the Hospital but everything possible was done to make the holiday as happy as could be for them. And even this number needed attention. The nursing and other staff worked without stint. We can surely say that Christmas was observed in proper style. Once more there was evidence of that esprit-de-corps which lives on at Guy's and of which we are very mindful when we say may you have a very happy and successful 1949.

Acknowledgement is due to Fox Photos Limited and to Miss P. Turnbull for the photographs reproduced in the last issue of the Gazette showing the picture in the College Smoking Room and "Boro' Olympics, 1948" respectively.

Wind

A Clinical Lecture given at Guy's Hospital on Tuesday, November 9th, 1948, by CHARLES BAKER, O.B.E., M.D., F.R.C.P.

GENTLEMEN,—Wind is a common complaint of many patients. It is important because it is a symptom which may lead us to a diagnosis of treatable disease and it is also a symptom which is often unassociated with organic disease at all. In such instances, though it may have no immediate or future effect on the physical health as occurs in Disease, it may constitute a grave Disorder which dominates the life of the patient and is an intolerable burden to those who have to live or associate with him. In addition, misinterpretation of the symptom may lead to misdiagnosis which may have far-reaching consequences and, whether it indicates disease or disorder, it is a symptom which is too often disregarded.

Patients have very definite misconceptions about Wind and it is essential that we should not fall into the same errors. They think it is always due to the production of abnormal gas in their insides and its not surprising that the more introspective should therefore assume that their intestines are diseased. They are unaware that it is normal to swallow air and that the mixture of the gases Oxygen and Nitrogen which constitute air are, in small quantities, normally present in the upper alimentary tract, nor that other gases are normally produced by bacterial fermentation in the lower alimentary tract. They make no distinction between air that is swallowed and gas that is produced and in this country both are politely called Wind. The American patient is more accurate when he complains of Gas, but one gathers that, although he is better informed on health matters by literary Digests, he is not much clearer on this digestive distinction.

Of the air which is normally swallowed, the Oxygen is largely absorbed, leaving the Nitrogen to be passed as odourless flatus, about a litre a day being the usual amount. To the Nitrogen from the swallowed air is added other gases produced by bacterial activity mainly in the large gut, some of which are also odourless. The smell of Wind is therefore not an absolute means of distinguishing between air swallowed and gas produced, but it is a useful index and one which the patient can understand. There is also an exchange of gases through the walls of the alimentary tract, according to the physical laws of diffusion of gases through a semi-permeable membrane. A mixture of gases is therefore normal in the stomach and bowels and while in normal conditions " the gentle wind does move, silently, invisibly," all are at times conscious of its presence. It is when the gases are in excess or the proportions are abnormal that it causes the distressing system of Wind which may, or may not, mean disease.

It will be convenient to consider the symptom in the three forms in which it may present. First there is Belching or Burping which is associated with gas in the stomach. Then Bloating or distension, in severe form known as tympanitis, which is often associated with pain and causes the patients to loosen their clothes. Thirdly is the passing of excessive amounts of flatus due to gas in the colon. It is a pity that the old English verb, both transitive and intransitive, to Fart is no longer " in decent use " (O.E.D.) for it is helpful in distinguishing between wind passed up and wind passed down. The polite

suppression of the word Fart and the survival of the word Belch in modern English usage is, of course, paralleled by the behaviour of the windy sufferer who conserves his lower wind for private expression but often fails to show the same consideration for others by belching in public. In practice, belching, bloating, and farting are often all present in the same case.

Belching.

Belching of gas other than air is uncommon. The hydrochloric acid prevents fermentation but in achlorhydria a small amount of gas may actually be produced in the stomach, particularly if there is delay in its emptying. The belching of foul wind may therefore be a symptom of carcinoma near the pylorus and the onset of this symptom in the middle aged or elderly without a history of previous indigestion is more than suggestive. In pyloric stenosis, with gross retention of the stomach contents, fermentation readily produces gases and " unpleasant " belching will occur. A few years ago there was a report in a medical journal of someone who lit a cigarette in the cinema, whereupon a sheet of blue flame shot forward over several rows in front of him. This story produced several letters recounting similar dramatic incidents but I must stress that it is not a common or presenting symptom in pyloric stenosis. Another condition in which foul wind may be belched is gastro-colic fistula where there is a communication between the stomach and colon, usually due to a neoplasm of one or other organ. Owing to the fact that " bowel wind " is belched, the patient is often shy to mention it and a leading question may be needed to elicit this diagnostic symptom. In this condition, which is not a common one, the small intestine is short-circuited so that there is no absorption of food and extreme wasting and diarrhœa results.

Wind which is belched is usually swallowed air. We know how the baby after its feed will bear witness with a contented burp that it has swallowed air. We experience the same thing when we bolt our food or when it contains large quantities of air as with new bread. An air bubble in the fundus of the stomach is normal and will be seen under the left lobe of the diaphragm by X-rays. An increased amount of air in the stomach will cause an uncomfortable feeling of fullness which is relieved when the excess is spontaneously removed by a belch or by the stomach contents moving on through the pylorus. The efficacy of Sodium Bicarbonate in such cases is due to the production of Carbon Dioxide which helps these two means of relieving stomach distension. But if belching is consciously resorted to, it defeats its object. Repeat belching is associated with further swallowing of air which adds to the air bubble, increases the discomfort, and so a vicious cycle of events is set up.

In what conditions is there excessive swallowing of air? First of all, excessive salivation will carry down air with the saliva and this will occur not only in painful and septic mouths but reflexly in nervous people and also in duodenal ulcer. It is very common in old people with uncomfortable mouths and unsatisfactory dentures; they suck there teeth and waggle their plates for hours on end and swallow air in the process, which is so often followed by belching, rumbling guts, and sometimes actual pain from distension. Next, diseases of the stomach and duodenum such as peptic ulceration and gastritis, gall-bladder disease, and cancer cause discomfort or pain which is temporally relieved by belching with consequent air swallowing. In such cases Wind may be an early symptom and particularly important in cancer of the stomach where diagnosis is so often too late. It will also occur in right-sided heart

failure and portal obstruction where the mucosa is congested, and in conditions away from the alimentary tract where pain, apprehension or discomfort is a feature, as in angina pectoris, extra systoles, paroxysmal tachycardia, asthma, or the raised diaphragm of pregnancy. It is particularly common in nervous, frightened, and anxious subjects both on the isolated occasion or as a more constant feature of nervous dyspepsia. Lastly, gas in the splenic flexure of the colon causes a feeling of fulness which is often aggravated by increasing the amount of air taken into the stomach. With all these conditions in which air swallowing occurs and belching is a symptom, the treatment will be that of the underlying cause of discomfort. It is, however, most important to explain the mechanism to the patient to prevent them adding to their troubles and they must be encouraged to refrain from belching and a simple carminative will often help them.

Far from uncommon is the patient where air swallowing or ærophagy has progressed to a habit which disorders his life and disgusts his relatives. It is here a hysterical symptom—a substitution for some past or present discomfort. It is also a presenting symptom—they belch in your face—and is a tic or habit which is increased when there are people about, whether they be sympathetic or not. You may distinguish the ærophagist from the patient whose wind is secondary to organic disease by the frequency as well as the blatancy of the belching, and those who start from the moment they wake in the morning and continue throughout the day are much less likely to have organic disease, and it is probably a nervous phenomenon. With most, a full explanation of the mechanism and encouragement to resist the desire to belch is sufficient. They must understand that it is a bad habit and an unpleasant habit and one that can, and should be, restrained in the same way that they deal with their flatus. Keeping the mouth open or biting on a large object which prevents swallowing may help to impress them that it is the intake of air into the stomach which causes them to bring it back, and it may even be necessary to convince them by showing them an X-ray of the air-bubble. In some, however, the neurosis is so entrenched or their nervous state is so deranged that simple explanation is not enough and a complete psychological investigation and psychotherapy is needed. It is a condition that is well worth taking trouble, not only for the sake of the patient but for those who have to live with the chronic belcher, for to them a cure is particularly gratifying.

Bloating.

Distension or bloating is usually associated with the symptoms of belching or farting, due to excessive air in the stomach or gas in the colon. This is particularly so when air is trapped in the upper part of the stomach and is not expelled, the condition known as Ærogastrie Bloquée. It may be caused by an inability to void an excess of air by belching as in spasm of the lower end of the œsphagus with œsophageal or high gastric ulcer, but more commonly where the air is not passed on because the stomach is divided into two by pressure from the colon which may itself be ballooned. Air blocking is therefore not necessarily associated with belching though this often aggravates it. Pain may gradually increase to great severity until it is relieved by the air passing on, which is sometimes facilitated by lying down, often face downwards, or its removal by an explosive belch or by the passage of a tube. The severity of the pain may suggest a coronary occlusion or abdominal emergency or, when the attacks are frequent, a peptic ulcer, and I have recently seen cases where these diagnoses have been made. The history gives the diagnosis

even if you do not witness the attack. Severe distension without passage of wind above or below also occurs in an interesting but rare condition where the diaphragm is kept in the position of full descent. Although it is most common where there is an unfulfilled desire for pregnancy—Pseudocyesis—it can occur apart from this and in males, and has led to laparotomy for a suspected growth or subacute obstruction.

Distension of the small intestine without the large intestine being affected is rare. It occurs either with failure of the normal movement of the small gut such as may occur in post-operative conditions and with severe illness such as typhoid or pneumonia, or with disease or congestion of the mucosa as in the congestion of heart failure or liver cirrhosis. The normal interchange of gas through the wall does not take place and the proportion of CO_2 and gases formed as the result of bacterial action such as H_2S or CH_4 will increase because of stagnation. There is again a vicious cycle in ileus. The absence of peristalsis impairs absorption of gas, and the increase of gas causes distension which further impairs peristalsis. It is interesting that a recent treatment for post-operative ileus is to decompress the intestines by forced respiration with Oxygen, the same method and mechanism as is used in denitrifying high-altitude fliers.

Excessive Flatus.

We come now to the third symptom, that of Farting, which is due to excess of gas in the large bowel. The commonest cause is constipation. The increase of wind in the large bowel will be due either to failure to absorb gas or to increased production of gas, and both these factors are favoured by constipation. There is diminished movement, and with impaction of hard fæces actual mechanical obstruction, which interferes with normal function and therefore absorption of gas, and with the stasis there is opportunity for increased production of gas due to bacterial activity. There is no need to emphasise the fact that in chronic constipation the production of large amounts of foul wind is common. The unpleasant gases arise from the breakdown of the end-products of protein metabolism by bacteria, with the production of what are euphemistically called "aromatic" compounds. The treatment of constipation I will not emphasise, except that habitual or excessive use of purgatives increases rather than decreases the production of wind.

Certain foods are wind-producing. It has been known since the time of Hippocrates that rough diet increases the tendency to wind, and that has been very apparent in this country since a higher reliance has had to be placed on carbohydrate and the vegetable foods. There is no doubt that more people have suffered and complained of wind in the last few years than was known before. It is sometimes said, particularly in America, that there is a definite allergy to wind-producing foods, but allergy is a very fashionable diagnosis on the other side of the Atlantic. Most of these foods actually are cellulose-containing, and I will go into the mechanism of that in a moment. Hinshore and Alverez went through a list of these foods, finding out which of them were notable wind-producers, and the conclusions they reached by that analysis are, on the whole, what one would expect from ordinary experience. Onions were at the top of the list. Cabbage, raw apples, radishes, beans, cucumber—all these substances, particularly in certain people, will produce wind and those people with sensitive and delicate insides should best avoid them.

But most of the wind due to intake of food is caused by abnormal digestion of carbohydrates. Normally carbohydrates are digested to sugar and absorbed in the small intestines without any difficulty, but the carbohydrates in vegetables with a cellulose covering are less accessible to the digestive ferments even when the envelopes are softened by cooking. If that digestion is delayed so that it begins to occur in the lower part of the small intestine or in the large intestine, bacterial activity results, with the production of acetic acid, CO_2, and butyric acid. That is the so-called Intestinal Carbohydrate Dyspepsia. It will occur if the contents of the small intestine pass quickly through before there is time for absorption, and fermentation continues in the large intestine. It will occur if there is failure of absorption as in sprue and allied conditions. It will occur if there is an increased amount of carbohydrates in vegetable form owing to the cellulose barrier. Vegetarians are notoriously "windy" persons, but the same thing occurs in other sensitive people if there is an excess of carbohydrates in the diet. Most people who have wind take themselves off meat and tend to rely on carbohydrates, which so often increases their disability.

The symptoms of carbohydrate dyspepsia are, apart from wind, pain around the umbilicus referred from the lower part of the small intestine, or more often in the right iliac fossa, where one can feel and hear the squelching of the cæcum. With it there is an associated desire to belch due to the accumulation of gases in the splenic flexure pressing on the stomach. In a severe case undigested food will be found in the stools, which, if incubated, will produce large amounts of odourless gas. The presenting symptom may be belching of wind though it is the gas in the large gut which is primarily the cause and the patient should be specifically asked whether, as well as bringing up wind, he is not passing wind, which is characteristically odourless.

Misdiagnosis of Wind.

Flatulent dyspepsia does not mean Cholecystitis though the gall-bladder is one of many causes of discomfort which may lead to air swallowing and therefore flatulence. I have an impression that chronic cholecystitis is less often diagnosed than it was when the radiology of the gall-bladder was not so efficient, and non-filling with the dye in a flatulent person might lead to a misdiagnosis. In the last year at Guy's there were 37 operations for gall-stones and only 6 for chronic cholecystitis without stones.

You have only to look at an X-ray where the left lobe of the diaphragm is ballooned upwards by gas in the stomach or splenic flexure to realise that "wind round the heart" is a very real thing. The heart can give evidence of temporary embarrassment by displacement due to wind and when pain is associated with the distension it is not surprising that a diagnosis of coronary ischæmia may be made. Temporary ischæmia or angina pectoris may, by its discomfort, cause air swallowing and belching, but careful questioning will show that the actual pain is short in duration and related to effort so that wind is not often mistaken for angina. But when wind causes prolonged pain and is associated with disturbance of the heart it may be mistaken for the prolonged ischæmic pain of coronary occlusion. This is not uncommon particularly in old people following an unaccustomed heavy or rich meal with the result that they are committed to bed for six weeks, and old people do not stand enforced rest well. In a wage earner it is also a serious thing, to say

nothing of the effect such a misdiagnosis may have on future activity and confidence. It is always worth bearing in mind Wind when you are faced with an atypical case of Angina or Coronary Infarction, and in such patients X-ray screening may show an association between wind under the diaphragm and their pain and a hold up of the swallowed barium in the œsophagus or top of the stomach. People who have " wind congealed round the heart " are naturally apprehensive that their heart itself has congealed and if the heart is normal, as it usually is, they must be told so.

In conclusion, the symptom of Wind is of significance and it is well worth while giving time and thought to it. It is very important to the patient and should not be brushed aside as a common triviality. I am reminded of a story in that excellent book of medical school life in Dublin by Oliver St. John Gogarty, " Tumbling in the Hay." The barman of the pub that the students used was a confirmed hypochondriac and he was always asking their advice on his many complaints, one of which was flatulence. One day he was telling them how he had sought the advice of a lady doctor. " I took her aside and confided to her my little trouble about the flatulence. ' It's only wind,' sez she. Think of her audacity! ' It's only wind,' sez she to *me*. ' *Only* wind? *Only* wind? ' sez I. ' Have ye never heard of the Tay Bridge disaster? ' "

Correspondence

A Comprehensive Library.

SIR,—A comprehensive library, especially of medical, dental and allied scientific periodical literature, is being formed at the Institute of Dental Surgery (British Postgraduate Medical Federation), Eastman Dental Clinic, Gray's Inn Road, London, W.C.1.

May I appeal to Guy's men for back numbers, bound or unbound, with indices, extending back for thirty years where possible, of the following :—

British Medical Journal, The Lancet, Journal of Dental Research, Nature, Journal of Pathology, Journal of Pathology and Bacteriology, British Journal of Nutrition, The Anatomical Record, Journal of Bacteriology and The Practitioner.

I am,
Yours, etc.,
W. G. CROSS,
(*Hon. Librarian*).

Eastman Dental Clinic,
The Royal Free Hospital,
Gray's Inn Road, W.C.1

Christmas Carols.

SIR,—Once again we would like to thank all those who turned out on a very cold night to induce Londoners to join in and sing Christmas Carols with them.

This year we were not allowed to collect for the " Guy's Children's Christmas Party " by name, but by the kindness of the Provost of Southwark we collected for his fund for Sick Southwark Children and most of the £66 18*s*. 1*d*. went to supply toys and amusements for the children in the wards of Guy's and the Evelina.

Yours, etc.,
M. COUPLAND.
W. DOBSON-SMYTH.
I. SCOTT.

Guy's Hospital, S.E.1

To Budapest—The Second Journey

By DAVID STAFFORD-CLARK.

(continued)

By now it was quite dark: the station lamps cast pools of light beside the halted train, and in the space between the tracks and the Customs huts a handful of soldiers with rifles slung over their shoulders patrolled slowly up and down. The new engine-driver, who was to take the train on from Szob to Budapest, wandered by outside the coaches, wiping his hands on a piece of rag. The old woman who shared the compartment with me leant out of the window and engaged him in a conversation in which I was able to join, with her as interpreter. He told us he earned 200 forint a week (about £5) and that this was enough for him and his wife and child to eat well—but to do little else. There was not much over for clothes, or cigarettes, or going to the cinema, he said. My interest in these rates of pay was to lead me to the surprising discovery that the engine-driver's salary was about three times that of the average doctor of registrar status in the hospitals of Budapest: but this subject will emerge again.

As soon as the train restarted the dining car was opened for dinner; last meal on the thirty hour train journey. On the tables the menus had been changed, not simply in content but in nationality: colour, size, description of the wagon lit service, all were different from before. The food was not noticeably transformed but the beer with it was no longer Pilsener, but Hungarian: only the waiters were the same. But it was not until I came to pay for the meal that I discovered the full extent of the change that had accompanied our crossing of the Danube. Politely but resolutely the attendant refused to accept my Czech currency: nor would he change it for me into Hungarian money. The same notes which earlier in the day he had gladly accepted for lunch and as a tip were now valueless: I must pay either in forint or in hard currency—dollars, or Swiss or Belgian francs. I had no forint, nor could I obtain any until I cashed a traveller's cheque—for which in these days in Europe a visit to a bank with passport is required: I saw no reason further to deplete my slender reserve of Belgian francs; deadlock appeared to have been reached. The situation was finally resolved by a fellow diner offering to change my Czech notes for me; but when we left the car together he returned them to me, explaining that he hoped I would not object but that in fact he had paid my bill since it was a privilege to entertain a delegate to the Centennial Medical Congress. Despite the personal charm of this gesture, my realisation that the notes had possessed even less value for him than for the train attendants, who would at least be re-entering Czechoslovakia on the return journey, did nothing to increase my confidence in currency arrangements in Central Europe.

We reached Budapest soon after 10.0 p.m.; officials from the Centennial Medical Congress with distinctive badges were on the platform to meet the train. After a rapid drive through the brightly lit but still bullet scarred streets to the Congress headquarters, I was identified, embraced, made most charmingly welcome, and taken to the Szent-Jstvan Hospital where I was to lodge for the next ten days.

The name Szent-Jstvan means Saint Stephen; he whose feast is mentioned in the Christmas Carol. The hospital on that first night reminded me of Guy's, for it consisted of a number of old stone buildings enclosing a central garden, with trees and a flowered lawn surrounding a fountain, not unlike the Park. By day the resemblance was to some extent maintained, since patients swathed in coloured blankets and dressing gowns were continually to be seen in this garden, and from time to time trolleys of drugs or dressings would be trundled across from one ward to another by porters; but there were no students, and instead of uniformed nurses and sisters were Nuns in their flowing black habits: for the nursing at Szent Jstvan is performed most efficiently by the devoted members of a Holy Order.

I was given a private room on the first floor of the Neuro-psychiatric block: the room contained a bed and a wash-basin, with wide shuttered windows opening out over the garden. On the wall above my bed was a Crucifix. At both ends of the corridor into which the room opened were wards: I had access to a bathroom adjoining one of them which also contained a most alarming but reputedly exceedingly efficacious piece of apparatus known as the Electric bath. This may be a familiar weapon in the armoury of the physiotherapists, but it was the first I had seen at close quarters. It was a large wooden tub generously interleaved with copper filaments connected by wires to a series of coils, batteries, valves and grids, and apparently controlled by a

switchboard which would have impressed even Baron Frankenstein. While I was sitting reflectively in the other and more familiar type of bath which the room contained the Nuns used to come bustling in and out, their sleeves rolled well up, and an expression of cheerful determination on their faces, to minister to this machine and prepare it for some willing victim. We invariably exchanged greetings on these occasions, but more ambitious conversations had to be carried on entirely by gesture.

The kindness and simple goodness of these women was overwhelming. During the ten days of my stay I was very rarely in the hospital for any meal except breakfast, and I had no precise way of conveying my plans to the Nuns except by pointing to my mouth and then waving my hands to and fro and shaking my head, to the accompaniment of much mutual smiling; yet whenever I returned during the day, to change my clothes or collect a coat before going out again, nods and smiles would greet my arrival and within five minutes tea or coffee or sometimes an entire hot meal would arrive on a tray. On my first morning there, as I was padding along to the bathroom in bare feet (a deplorable habit for which there is no excuse) a Nun swooped down in front of me like a swallow and deposited two raffia slippers for me to step into; they remained at my disposal for the rest of my stay.

My immediate host was the first assistant to the Professor of Neurology; he was a man of about thirty, and a member of the Communist Party. Membership of the Party, in this as in other countries, is restricted to a small section of the population, but this section contains a high proportion of professionally and technically competent people. I am not a Communist, being unable to accept either the validity or the ethics of dialectical materialism, but I went to Hungary with the intention of observing rather than arguing with my hosts, determined to reap a rich reward in experience—which I did—but not anticipating invitations to general criticism or to open political arguments. Here I was partly wrong: not once but several times Hungarian Communists deliberately raised controversial topics relating both to foreign affairs and to current internal measures and, in the most frank and friendly manner, asked my views. Sometimes we were able to agree about a specific issue: more often our disagreement was fundamental and extreme. Interesting and in some ways encouraging as these discussions were, I did not disguise my realisation that they would not have been possible had I too been a Hungarian instead of a foreign visitor; nor did they. Discussing England they found it incredible that any English man or woman not a convicted criminal could obtain a passport simply by sending 15*s*. and an application form to the Foreign Office; that we had no political prisoners; and that Harry Pollitt could hire the Albert Hall for a political meeting if he wanted to.

In the course of discussions with medical colleagues I learned that the average monthly salary of a registrar in Budapest was about 300 forint; roughly about £8. As it is quite impossible to live on this, Registrars are compelled to compete at a considerable disadvantage with the Professors in private practice, and also find it virtually impossible to refuse the presents in kind—eggs, or cheese, for example—which patients in the general wards offer them whenever they can as a mark of gratitude or an insurance of favourable attention. The financial status of most of these patients is similar to that of the patients in Guy's, and no one is more keenly aware of the unsatisfactory nature of the present system of remuneration than the doctors themselves; but until their salaries are increased there is little they can do about it. That their salaries will be increased, and that fairly soon, seems certain: they themselves point confidently to the example of Soviet Russia, where doctors are well paid. But in this connection it is interesting to remark that when any of the less desirable developments in the U.S.S.R. are pointed out to them, such as the growth of a secret police, political control of judges and justice, and the withdrawal of individual rights to a passport, free speech, or a free secret vote, as the basis for western misgivings as to the future of individual happiness in their country, they at once reply, "Ah but you mustn't assume that Communism here is the same thing as Communism in Russia. . . ."

I had arrived in Budapest on the night of Saturday, September 4th; the Centennial Conference began on the morning of Sunday, September 5th with a grand inaugural meeting in the Musik Halle; a building corresponding to the Queens Hall in London. The inside of this hall was crammed with people and festooned with scarlet and red and green banners. Above the platform were a number of enormous black and white photographs or drawings of the kind familiar to students of totalitarian propaganda, each representing the head and shoulders of a Famous Man. This particular collection included Stalin, Lenin, Karl Marx, the Hungarian Minister of Health, the President of Hungary, the Leader of the Communist Party, and somewhat isolated among this

political galaxy, Professor Semmelweiss, who some hundred years previously had made a pioneer study of puerperal fever. The speeches were all in Hungarian and almost entirely political: once the general effect of this characteristically staged orgy had sunk in I was ready to leave, and left.

I spent the rest of the morning completing registration formalities at the Congress headquarters, where the political police paid delegates the courtesy of being present in person to take charge of their passports for 24 hours to stamp and sign them, thus obviating the necessity to report in person at police headquarters. I then paid a call on the British Consul and his wife, who had been kind enough to invite me round to their house for a drink. In the afternoon, I went up into the hills behind Buda, on the western bank of the Danube, to visit a Catholic priest of whom I had been told.

He was one of the most remarkable men I have ever met. He lived in a house adjoining the Buda mental hospital at whose chapel he used to say Mass every morning: apart from this daily office and occasional walks in his garden, he had not left his house for twenty-five years, since a cerebral vascular catastrophe from which he had almost died. He was now still handicapped by a complete agraphia, having relearnt to write his name only after tremendous efforts; but of the earlier hemiplegia, aphasia and alexia from which he had suffered there was almost no sign. Before his illness he had been a member of a most active Order, had travelled widely and taught in the Cardinals' College in Rome: now, confined in body, he had none the less completely transcended his physical handicap. From all over Hungary, and from the most distant parts of Europe, travellers came to visit him, to hear his clear and kindly views, to enjoy the general stimulus of his conversation, and to regain faith and understanding from the wide range and profound depth of his observation and interest in life, his wisdom and his enduring courage. He radiated enthusiasm and love for his fellow men, while remaining acutely alive to their failures and weaknesses, and to his own. He was particularly interested in England, and in the resurgent inspiration of certain modern English writers; particularly Evelyn Waugh, Graham Greene, and Rex Warner, who was himself once a Communist:

"In times of spiritual crisis," he said, "there arises always in England men on fire with Faith and the Love of God: in this way indeed can England prove herself the hope of all the world. . . ."

Tall, noble, his fine face always reflecting vividly the concern, pity, joy or warm amusement of the immediate topic of conversation, he attracted to his house not only fellow members of his Church but also some orthodox Communists who recognised in him a power, a wisdom and a splendid simplicity that they could not deny, inexplicable as they might find its origin. Conversations with his guests would take place on a terrace paved with crumbling flagstones between which grew flowering weeds and grasses. The terrace overlooked a sloping overgrown garden which dropped away steeply so that the view extended beyond the tops of wild rose trees, over a line of poplars, to the distant hills and mountains, while below them, far down in the valley were the spires and domes of Old Buda. We sat there that first afternoon from about three to nearly eight, by which time the dusk had come down to the poplars and the lights were beginning to sparkle in the distant city, while the air was heavy with the sound of the cicadas. I came again to see Mon pére several times during the Conference in which he took a characteristically lively interest; on one occasion he took me into his study to show me his life's work. The walls were lined with bound manuscripts, books typed to his dictation by a faithful amanuensis, one of several devoted old women who lived in the house to look after him. These books, for which publishers were already waiting, ranged in subject from philosophical and theological works to a critical analysis of Shakespeare's plays from the standpoint of the Seven Graces and the Seven Sins of Man.

"But when will these be published?" I asked.

"When I am dead," he replied, his eyes twinkling with amusement.

"Why not before, Mon pére?"

"It is my fancy. I am about this perhaps what you would call 'fou': a 'twentieth person.' . . ." He was referring to the press report of a paper read by a Hungarian psychiatrist at the Conference, claiming that every twentieth person consulting a doctor in Budapest was insane. This statement had delighted Mon pére, who had eagerly asked me for my views about it. I had said I had thought the report must be an over simplification.

"Yes," he remarked wistfully, "but it is an appealing idea, is it not, this of the twentieth person?"

" It is indeed."

" Perhaps after all it is right : it would explain a lot of things."

Some months before a number of detectives had been posted to maintain continuous surveillance on Mon pére's house. He described this period to me with cheerful gusto.

" Every time someone come to the front door or the garden gate to visit me, these gentlemen who are standing about outside blow whistles to each other. So even if I or Maria or Rosicka or the others do not hear the knock or the bell, we hear the whistle and we know there is somebody come to see us. It is most helpful. But always the gentlemen stay outside. One day I go to the hedge and call through to them : ' Come in gentlemen please, take a glass of wine with me, and enjoy the conversation : you will hear so much better in here than out there.' But they are sad, they may not.

Eventually they are taken away. I think they find me so dull, it is very disappointing to the authorities."

Ten days after my return to England I learnt that he was dead : he had had a further cerebral hæmorrhage. I believe him to have been a saint.

(*To be concluded*)

Miscellaneous

CONGRATULATIONS are offered to Sister D. Jackson who has obtained the Midwives' Teachers' Diploma of the Royal College of Midwives, and to Miss Hickson, Sister-in-Charge of the York Clinic, who has obtained the Diploma in Psychiatric Nursing of the University of London.

DR. JEROME P. WEBSTER, M.D., Plastic Surgeon, Presbyterian Hospital, Columbia Medical Centre, N.Y., Consultant Plastic Surgeon to the U.S. Army and Chairman of the Board of Plastic Surgery, recently visited Guy's and gave a lecture on " The Scope of Plastic Surgery." Dr. Webster had only four days in England while en route by air from China to the United States and this lecture was one of only two official engagements he was able to fulfil in this country. Besides giving a most instructive talk about his work he showed a series of very beautiful coloured photographs of major repairs carried out in all parts of the body.

COL. LINDSEY TASMAN RICE, an account of whose spectacular career appeared in the *Gazette* on 5th June, 1948 (No. 1562, pp. 157–159), has been appointed Vice-Chancellor of the University of Hongkong where he has already held the positions of Professor of Physiology and Dean of the Faculty of Medicine.

Guy's Diary

JANUARY

ACADEMIC

Jan. Exhibition. Surgical Dept. " Goitre."

3rd. 1.00. Dr. Crisp. Clinical Lecture. " Fibrositis."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
4.30. X-ray Meeting. Gordon Museum.
5.00. Dr. P. Polani. Pædiatric Department. Postgraduate Lecture. " The Adrenal in Childhood." Preclinical Classroom.

7th 12.00 Dr. Waterfield Dental Clinical Lecture. " Diseases of the Blood in Relation to Dentistry " Dental Theatre.

8th. 10.00. Mr. Charles Donald. London Hospital. Surgical Departmental Round. Clinical Theatre.

10th. 1.00. Mr. Atkins. Clinical Lecture. " John Hilton.'
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. D. Beynon. Pædiatric Dept. Postgraduate Lecture. " Trends in the Treatment of Gastro-enteritis." Preclinical Classroom.

11th 1.00 Prof. Spurrell Clinical Lecture. " *Rest* "

13th. 4.30. X-ray Meeting. Gordon Mueum
5.00. Dr. Kiefer, Lahey Clinic, Boston. Film, " *Peptic Ulcer.*" Anatomy Th.

14th. 1.00. Dr. *Campbell.* Clinical Lecture. " Bacterial Endocarditis."
2.15. Medical Dept. Combined Round. Preclinical Classroom.

17th. 1.00. Mr. Morgan. Clinical Lecture. " Virus Diseases of the Eye."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. P. R. Evans. Pædiatric Dept. Postgraduate Lecture. " Hydrocephalus" Preclinical Classroom.

OTHER ENGAGEMENTS

Jan.

3rd. 7.30. Resident Maids' Party and Entertainment.

6th. 8.00. York Clinic Party.

7th. 3.00. Daily Workers' Party.

8th. Rugby XV. *v.* Wasps (Sudbury).
Hockey 1st XI. *v.* South Saxons (H.O.P.).
Hockey 2nd XI. *v.* South Saxons (Away).

15th. Rugby XV. *v.* Old Alleynians (H.O.P.).
Hockey 1st XI. *v.* Hendon (Away).
Hockey 2nd XI. *v.* Hendon (H.O.P.).
Hockey 3rd XI. v. Hendon (Away).

Sport and Hospital Information

FENCING

The first team has played two three-weapon matches this term, both being held in the Pavy Gymnasium. That against Cambridge University, on 6th November, was lost by fourteen fights to twelve, despite winning the épée. On 6th December a severe defeat was suffered at the hands of Salle Paul, mainly owing to a loss of 8—1 in the foil. The final score was 18—9.

Nor has the second team been successful. In its two matches, played against King's College and Toynbee Hall, losses of 9—7 and 6—3 were the best that could be achieved.

However, in the field of individual events, better results can be recorded. Scott won the épée in the University trials, and came second in foil; Wilson won all his preliminary fights in sabre, but was unable to play in the final pool. Wilson has been elected Captain of the University fencing team.

BOXING CLUB

We were very pleased to welcome Trinity College, Dublin, to Guy's once more for their fourth fixture with us. An Inter-Club Tournament was held in the Pavy Gymnasium on the 3rd December. There was plenty of support and shortly after 6 p.m. a good crowd came along to see what they knew would be a good evening's entertainment.

There were seven inter-club contests with three extra bouts in which Guy's Club members took part.

Trinity won the Inter-Club Tournament by four bouts to three after a very keen show of boxing.

Dr. Keith Simpson very kindly presented the prizes after saying a few words from the ring. Extra plaques were presented to the two seconds, Frank Kerr and Matt Wells as tokens of remembrance.

We would like to express our regret that there was not more room for spectators, and we do hope that there will be plenty of support from the members of all departments of the Hospital at our next Inter-Club Show with St. Mary's Hospital at Seymour Hall on February 22nd. To add to this needle attraction, amateur champions and other top ranking boxers have been invited to take part in this show.

Tickets will be obtainable in the new year.

INTER-CLUB BOUTS.

Results.—Guy's boxers' names first.

Feather-weight.—R. Thompson lost to P. Stewart on points.

Light-weight.—W. Watson lost to D. Keegan, 2nd round.

Welter-weight.—M. Mason beat I. Meares on points.
A. Atkinson beat R. McCulloch on points.

Middle-weight.—P. Lansdown lost to T. Bamford, 3rd round.

Light-heavyweight.—M. Hughes lost to R. Jevers on points.

Heavy-weight.—R. Walsh beat J. Nisco on points.

CLUB BOUTS.

Middle-weight Bouts.—
R. C. Thompson beat M. Griffiths on points.
M. O'Reilly beat G. Maggs, 2nd round.
D. Lipington beat N. St. John on points.

NOTICES

DEPARTMENT OF MEDICINE

A revision course for the March M.R.C.P. will be held, commencing 7th February, 1949. The course will be limited to twelve vacancies. Details of the Course will be posted on the Department of Medicine notice board. Application forms, which must be completed by the 14th January, 1949, may be obtained from the Department of Medicine.

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School for two Scholarships, tenable in the United States of America. One Scholarship is offered by the Northwestern University, Chicago, and the other by the University of Loyola, Illinois. Both Scholarships cover the cost of tuition fees.

Full particulars can be obtained from the Dean, Medical School Office, Guy's Hospital, S.E.1, from whom forms of application may be obtained. Closing date for applications is Saturday, 31st January, 1949.

UNIVERSITY OF LONDON

Special University Lecture in Dentistry.

A Lecture on *The Influence of General Health Supervision on the Frequency of Dental Caries in Groups of Norwegian Children* will be given at the Universi y of London, The Senate House (entrance from Russell Square, or Malet Street, W.C.1), by Professor G. Toverud (Director of the Department of Pedodontia, in the Dental School, Oslo), at 5.30 p.m., on Wednesday, 12th January, 1949. The lecture is addressed to students of the University and to others interested in the subject. Admission free, without ticket.

PASS LIST

UNIVERSITY OF CAMBRIDGE

M.B.

FINAL EXAMINATION.

Michaelmas Term, 1948.

Part II.—Principles and Practice of Physic, Pathology and Pharmacology.

R. D. Allen.

Part I.—Surgery, Midwifery and Gynæcology.

C. C. Clapham I. P. James J. F. Soothill

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

D.R.C.O.G.

November, 1948.

V. Y. Bockner H. A. Rowley
H. F. Hills R. N. H. Vann
I. Macdonald

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.R.C.S.

P. G. Large N. F. W. Salmon R. N. Ticehurst

D.A.

O. H. E. Bayles D. H. Couch

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.D.S.

E. J. Dalling H. H. Kenshole J. W. Mansie

INTERNATIONAL NEUROLOGICAL CONGRESS

Dr. M. J. McArdle has been appointed Treasurer and Sir Charles Symonds, a member of the British National Committee, for the 4th International Neurological Congress, Paris, September 5th to 10th, 1949.

BIRTHS

HAMMOND.—On December 22nd, 1948, at Purley, Surrey, to Kathleen (née Arnott), wife of E. C. Hammond, L.D.S.—a son.

KEATES.—On November 2nd, 1948, at Guy's Hospital, to Mary (née Bowra), wife of M. D. Keates—a son (Peter Robin).

Eds. {H.A.R. R. G.

SANTRON the New Germicide

- **Gynæcology and Midwifery** — Contains a higher percentage of pure potash castor oil soap, and differs from most germicides in that an additional soap solution is not required when used in Gynæcology and Midwifery. It is clean and pleasant in application, and is safe in undiluted form.
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- **In General Practice** — Santron is available to the Public through Chemists, and may be indicated for all purposes of personal hygiene including gargling, as a deodorant, and general disinfecting of sick rooms, and treatment of clothes.
- **In the Home**

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GUY'S HOSPITAL GAZETTE

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PASSIM

IT is nearly two years since we announced in Passim that, through the generosity of the Master and Wardens of the Clothworkers' Company in London, and the Johns Hopkins Foundation in America, there was to be a series of visits payed to Baltimore by our staff, and by their physicians and surgeons, to us at Guy's. Our fourth representative in this interchange scheme has lately returned, and in this and subsequent issues of the *Gazette* there will be found an extensive report by him on the surgery he has seen and the lessons he has learnt. It is extensive at *our* request, because we felt that as many people as possible should benefit by the experience of the individual, and learn not only what the Johns Hopkins is doing and thinking that is good, but how good it is and why. There is no doubt that we in England have a great deal to learn from them, and in part the reason can be found by a study of the machinery which moulds the young doctor into a member of the staff at their great hospital. The description given by Mr. Atkins in his article, of this system for developing the promising surgeon will, to many of us, be something of a revelation. It is a fine example of American thoroughness, and it would seem a wonder that our apparently haphazard methods of postgraduate education have ever produced anything comparable with those giants on the other side of the Atlantic. While knowing that they have, one cannot help feeling that boatloads of wisdom are being shipped across that broad ocean from West to East, and wondering what is carried back. But it is common nature to appreciate the influence of others while failing to observe the influence of oneself. It would be interesting to know what it is that the Americans find most acceptable amongst our offerings. To be sure, in our herbaceous borders, there grow flowers which suffer nothing by comparison with the hot-house plants of Baltimore. We grow for example, in some profusion, a breed of general practitioner that is the finest in the world. Nourished by humility amongst humanity he has a balance and a breadth of outlook to offer to the common man with the common ailment that is without compare. And our nurses, living (or partly living) and learning the hard way, with little of cromium to help, but hearts of gold—for all our random methods of cultivation, do these not make as great a show as any? Of course the Americans have much to teach us, and we have the will to learn. But we have also some fine produce to offer at our stall, grown in the old world way in our old world plot, and of which we have nothing to be ashamed.

THE British Council has arranged for Miss Emily P. MacManus, Matron of Guy's Hospital from 1927 until 1946, to go to Turkey at the beginning of February for a two weeks' lecture tour.

The tour, which is being arranged in co-operation with the Turkish Ministry of Health, is of particular interest at the present time as the Turkish nursing services are in process of reorganisation. Turkey, too, is faced with the problem of attracting girls to the nursing profession, and Miss MacManus has been asked to talk to school girls and the general public about the life of a nurse in Britain, as well as to professional audiences.

Her specialist lecture subjects will include "Modern nursing services in Great Britain," "Organisations of a modern school of nursing," and "A nurse's place in the health services of her country."

Miss MacManus will probably leave by air on February 9th and return on February 23rd. We wish her a good trip.

D. H. KELLER, who played for the Wallabies in their Rugby Tour of this country last winter, and recently came to Guy's as a House Surgeon, has been selected to Captain Scotland against France in the first international match of the season. We would like to offer him our congratulations.

THIS year's Residents' Play is about to go into production, and as is usual, there is a serious shortage of talented assistance. Two pianists, a stage manager, electricians and stage hands are wanted, and it is traditional that students should fill some of the gaps. Would anyone interested please contact the President of the Residents.

C. W. WILSON, B.Sc., M.R.C.S., has left, and H. A. Hughes, B.Sc., and R. W. Stanford, M.A., have joined the staff of the physics department.

ON account of the Christmas holiday, proofs of the last issue were corrected with unaccustomed haste. We must apologise for two misprints on pages 12 and 12a. Colonel Rice should read *Ride*, and in the pass list of the F.R.C.S., N. F. W. Salmon should be initialled *L. F. W.*

We might add that Mr. Salmon, together with Mr. A. Young who was until latély a Temporary Assistant Surgeon in the oto-rhino-laryngological department, are the first two surgeons from Guy's to pass the recently instituted F.R.C.S. in Ear, Nose and Throat surgery.

Because of the shortage of space, David Stafford-Clark's final article on his travels has had to be held over until the next issue.

Blue Cloth Binding Cases for The *Gazette* may now be obtained from the *Gazette* Office and Wills, Library at 3*s.* 6*d.* each, post 3*d.* extra. We would also remind our readers that the annual subscription to the *Gazette*, 12*s.* 6*d.* per annum, post free, including the "Directory of Guy's Men (Medical and Dental)," as and when published, is now due and, if not already paid, should be forwarded to the Manager, The *Gazette* Office, Guy's Hospital, S.E.1.

Guy's Diary

JANUARY

ACADEMIC

Exhibition. Surgical Dept. "Goitre."

17th. 1.00. Mr. Morgan. Clinical Lecture. "Virus Diseases of the Eye."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. P. R. Evans. Pædiatric Dept. Postgraduate Lecture. "Hydrocephalus." Preclinical Classroom.

18th. 12.00. Prof. W. E. Herbert. Dental Clinical Lecture. "The Pathology and Treatment of the Exposed Vital Pulp." Dental Theatre.
12.00. Dr. McArdle. Neurological Demonstration. Preclinical Classroom.

20th. 1.00. Mr. Eckhoff. Clinical Lecture.
4.30. X-ray Meeting. Gordon Museum.

21st. 2.15. Medical Dept. Clinico-Pathological Conference. Pathology Lecture Theatre.

22nd. 10.00. Surgical Dept. Clinico-Pathological Meeting. Anatomy Theatre.

24th. 1.00. Dr. E. B. Reeve. Clinical Lecture. "The Use of Radio-Active Isotopes in Medical Research and Treatment."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. Elaine Field. Pædiatric Dept. Postgraduate Lecture. "Reversible Bronchiectasis." Preclinical Classroom.

25th. 1.00. Dr. Baker. Clinical Lecture.

27th. 1.00. Mr. Lawrie. Clinical Lecture. "Management of Head Injuries."
4.30. X-ray Meeting. Gordon Museum.

28th. 2.15. Medical Combined Round. Preclinical Classroom.

31st. 1.00. Dr. Rink. Clinical Lecture. "Complications of Anæsthesia."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. Vertue. Pædiatric Dept. Postgraduate Lecture. "Pleasure at the Helm: The Treatment of the Normal Infant."

SPORT

22nd. Hockey 1st XI. *v.* Woolwich Polytechnic (H.O.P.).
Hockey 2nd XI. *v.* Woolwich Polytechnic (Away).
Rugby XV. *v.* Metropolitan Police (H.O.P.).

29th. Hockey 1st XI. *v.* Ealing Dean (Away).
Hockey 2nd XI. *v.* Ealing Dean (H.O.P.).
Rugby XV. *v.* Devonport Services (Devonport).

Some Lessons of the Exchange, 1948

By H. J. B. ATKINS, D.M., M.Ch., F.R.C.S.

THE visitor to the Johns Hopkins Hospital, or the " Exchange Professor," as he is encouragingly called, brings away with him a kaleidoscopic picture of almost bewildering activity. He operates and he watches operations, he lectures and listens to lectures, he attends conferences, clinics and ward-round at all of which he is expected to contribute to the discussions ; he teaches the fourth year students, gossips far into the night with Interns and Residents avid for information, and on top of all this he is entertained, " off the field " as it were, with a regal magnificence that more than justifies the reputation of Maryland as the " Hospitable State " in the most hospitable country in the world.

The range of activities at the Johns Hopkins is such that five weeks is far too short a time to devote to the study of this one hospital alone. Work in the Department of Surgery begins at 8 a.m. and eases off round about midnight, although the cafeteria stays open until 3 a.m. to supply coffee and " cokes," cheese, eggs and ham to belated Residents wrestling with the last fractures, perforations, hæmorrhages, stab wounds of the heart and acute gall-bladders.

One can say right away that the all round standard of surgery is unsurpassed in any other clinic in the world. The tradition of Halsted is everywhere pervasive, while the spirit of his teaching and the general excellence of performance are maintained in every field by the example and devotion of the present professor—Dr. Blalock.

They have their difficulties nevertheless. The first is finance, and the intense interest displayed by every member of the staff in the experiment of the National Health Service Act in England betrays an anxiety that when (most that I talked to would say " when " rather than " if "), when the public purse comes to the rescue of American hospitals, they will profit by the lessons that we are learning " the hard way." The recent presidential election is said to have brought this chapter in the history of American medicine a stage nearer and, with the best will in the world, the ' Exchange Professor " is unable to avoid discussing this matter both in private, in after-dinner speeches and even more public places where quick-firing and indefatigable newspaper reporters elaborate every nuance and interpret each innuendo in the manner best suited to the policy of their editorial staffs.

The second problem is nursing. The lack of nurses in American hospitals would appear to be quite as acute as in the hospitals at home. Recently an experiment was tried at the Johns Hopkins to raise the status of the nurses by admitting only university graduates, but this policy was a failure and led to an even greater shortage. Thus expedients such as we have tried, the enlistment of nursing aides in a lower category and other measures, have failed to solve the problem, and the most distressing course of all has had to be adopted, one hopes only temporarily, that of cutting down beds.

To understand the work of the Surgical Department at the Johns Hopkins, it is necessary briefly to describe the system of staffing which prevails there. All the surgical beds are under the whole-time Professor, who uses a small proportion of these himself, the rest of the operating being delegated to his

two Residents and through them to the Assistant Residents. He is in addition helped by three or four whole-time workers, some of whom will take charge of special fields such as neurosurgery, orthopœdics and so on. There is no doubt that the "big shots" are the two Residents, and as the "Resident system" is one which is being adopted by more and more American hospitals it will be necessary to examine these gentlemen more closely. First let me say that to hold the appointment of Resident at the Johns Hopkins Hospital implies that a man is a surgeon of quite superlative quality and considerable experience. His career has been one of financial stringency and "nose to the grindstone," devotion to his work that demands courage, determination and simple physical stamina, as well as ability. Having completed his term as Intern (House Officer) the selected trainee is sent into experimental surgery for one or even two years. Here in "the dog-house," of which more anon, he becomes technically accomplished to a degree which at such a tender age is impossible in our country. The man of twenty-six or eight who can anastomose the carotid artery to the coronary sinus in fifty dogs with a negligible mortality, or who has done a similar number of vagotomies, gastrectomies, colon resections, and other manipulations on the small-scale anatomy of the dog, without a post-operative death and no morbidity, has a confidence in tissue-craft which is at the least going to ensure competence, and may promise great achievements. During this time our future Resident not only acquires technical competence, but has time to think, and is given every facility for working out problems in surgery or surgical physiology which may suggest themselves to him, always under the guiding stimulus and encouragement of the professor.

At the end of this time he will be appointed Assistant Resident (Registrar), and here for three or four years he will act as first assistant for operations conducted by the Professor or the Resident, and will himself do all the "bread and butter" surgery of the department. Finally the selected Assistant Resident will become full Resident, an office which may be held for four to eight years. During this time he will operate three or four times a day on major cases, such as "blue babies," total gastrectomies and œsophagectomies, and will often have worked out for himself a special line about which he has pondered, on which he has written, and in which he is in a fair way to becoming an acknowledged expert. The final destination of Hopkins Residents is usually as might be expected, to professorial chairs all over the country.

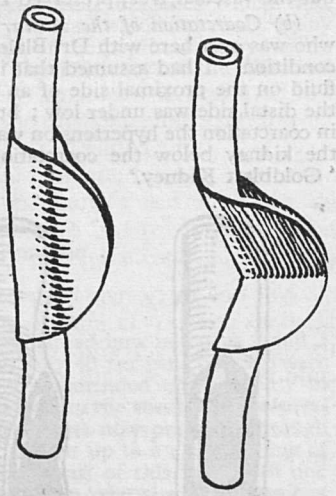
Not one in twenty becomes full Resident and at all stages in their careers Hopkins men go out into the country to practice surgery in hospitals throughout the length and breadth of the land. Some go early into small hospitals or country practices, others, after some years as Assistant Residents, to larger hospitals and more populous communities, but all take with them that essence of Hopkins surgery—the capacity to perform careful, unhurried, scrupulous work.

Outside this system and complementary to it, is the part-time staff. These surgeons, usually Associate Professors to the Medical School, fill the private and semi-private beds of the hospital. They are assisted in the theatre by the Assistant Residents and their influence on the teaching of surgery is considerable. The part-time staff attend surgical conferences and clinics, and should it ever be (though the situation is hardly conceivable) that the Professor were a figure of less than world renown, the part-time staff would still maintain the standards of the hospital, and impart to the Assistant Residents and so

to the future Residents, modern and exact surgery distilled from the reservoir of the Halsted tradition.

Now for a specific survey; first in the general field. The technique of scrubbing for an operation is uniform throughout the hospital and is based on careful bacteriological experiments. The hands, forearms, and arms for a few inches above the elbow, are scrubbed with soap and water for three minutes, the nails are then tended with an orange-stick, and the hands and forearms up to the elbows scrubbed for a further five minutes. The hands and forearms are then scrubbed with towelling soaked in seventy per cent. alcohol for a final three minutes. The surgeon then dries his hands, his gown is handed to him by the "scrub nurse," and having put this on he powders his hands and plunges them into rubber gloves held open for him by the same nurse. Finally he rinses his gloves in saline to rid them of all traces of powder, which if implanted into the peritoneal cavity might cause a granuloma, and dries them with a piece of gauze.

The operation now proceeds and, in style and approach, is what we are used to at Guy's. There are, however, one or two points of contrast which might be remarked upon. Firstly, the sucker is used ubiquitously as a retractor, as a blunt dissector, and sometimes even as just a plain sucker. This keeps the field, already scrupulously hæmostatic, virtually dry, but might in some cases deceive the operator as to the amount of blood lost—the point is a debatable one. Secondly, diathermy coagulation is used to a greater extent than with us, and this often with the patient receiving ether anæsthesia. Intravenous infusion is used routinely in operations where we might consider this unnecessary, but the organisation for its administration and the care with which it is set up are models of efficiency. An extremely effective control, instead of our "gate clip" is the use of the malleable metal disc which seals the glucose saline bottles. This disc is doubled over the feed tube (which is commonly of plastic material, and which is so cheap that it can be discarded after use, thereby avoiding reactions due to pyrogens left behind in an imperfectly cleaned rubber tube) and the now semi-circular double disc can be "broken" to any desired angle and so regulates the flow very exactly. (Fig. 1).



(Fig. 1)

Antibiotics, of which there are a prodigious range, are employed to combat every infection. Penicillin still holds pride of place, but streptomycin is used on a formidable scale whenever a "gram-negative" infection might be anticipated, and the new antibiotics which can be taken by mouth, such as aureomycin or bacitracin elaborated by Dr. Meleney, together with literally dozens of others, bid fair to take the place of streptomycin and penicillin as soon as their exact indications, toxic propensities and other problems related to their large-scale production have been worked out. In the chemical fields too, "D.F.P." (Di-isopropyl—fluorophosphate), a by-product of chemical warfare, which is an anti-cholinesterase is used in place of acetylcholine in the treatment of established or incipient paralytic ileus, and is said to be very

effective. Teropterin, recently reviewed in the British Medical Journal, has been experimented with as a carcinolytic agent, and a new material, aminopterin, thought to be an anti-œstrogen, holds great promise.

The present Residents hold what we might consider somewhat extreme views on the subject of early ambulation, practically all cases getting out of bed on the evening of their operation; and on one occasion I went into a ward to see a boy from whom I had removed an appendix for acute appendicitis two days before to find that he had been discharged to his home!

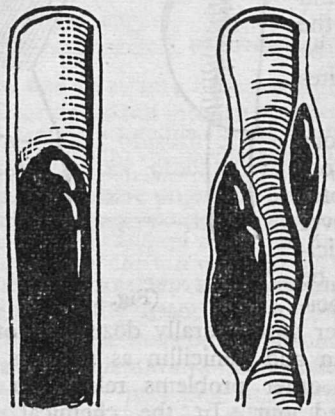
CARDIO-VASCULAR SURGERY.

Ever since the time of Halsted, the Hopkins has been a leader in cardio-vascular surgery and, with the proclivities of the present Professor in mind, it will be readily understood how advances in cardio-vascular surgery constitute one of the most prolific activities of that institution to-day. It will be necessary therefore to consider this branch of surgery in some detail and we can evaluate the lessons learnt under three headings.

1. CLINICAL.

(*a*) *Arterio-venous aneurysms of the lung.* This rare condition of which they have had five cases at the Hopkins is of special interest to them in the physiological problems of oxygen saturation and the like which it poses. The cases are fully investigated from the point of view of localisation of lesions (they are often multiple), and of cardiac physiology by the techniques presently to be described, using intra-cardiac catheters. Occasionally these lesions are bilateral, when they are outside the range of therapy, but if unilateral they are treated by lobectomy or pneumonectomy according to their extent. Dr. Clay, one of the two Residents, has prepared beautiful dried specimens of these aneurysms by washing through the vessels of the excised lobe with water and injecting vinylacetate into the feeding artery. This is usually mixed with some radio-opaque material so that, at the same time, radiographic studies of the specimen can be made. The specimen is then digested with pepsin and hydrochloric acid so that all but the vascular tree, preserved by the vinylacetate, is dissolved away.

(*b*) *Coarctation of the Aorta.* I discussed with Dr. Bahnson, Assistant Resident, who was over here with Dr. Blalock last year, the pathology of the hypertension in this condition. I had assumed that it was simply a hydrostatic phenomenon whereby the fluid on the proximal side of an obstruction was under high tension, whereas that on the distal side was under low; but he told me of work which tended to show that even in coarctation the hypertension was probably renal in origin, the trickle of blood reaching the kidney below the coarctation initiating the familiar anoxæmic processes of the 'Goldblatt Kidney.'



EMBOLUS. THROMBUS.

(Fig. 2)

(*c*) *Peripheral Vascular Diseases.* Whilst I was at the Hopkins we had a distinguished visitor in the person of Professor Fontaine from Strassbourg, who had been Professor Leriche's first assistant when he was Professor there, and who gave three talks on peripheral vascular disease. The following is an epitome of what he told us.

Professor Fontaine spoke about arteritis in association with arterio-sclerosis, and the complication of arterial blockage from clot.

(1) Acute obstruction. The first question is whether the arterial obstruction is due to embolism or acute thrombosis. Often the evidences of aortic vegetations or other clinical signs will make the possibility of embolism rather than thrombosis the likely one, but in any case arteriography should be performed. This will determine the differential diagnosis with exactitude

and will also localise the embolism precisely should it turn out to be this. (Fig. 2). Embolism is treated by embolectomy, and even in acute thrombosis, if recent, Professor Fontaine thought that a direct attack on the artery was the wisest course. In discussion subsequently some members of the Hopkins staff thought, however, that in the acute thrombus cases an alternative and perhaps better procedure would be heparinisation plus sympathectomy.

In discussing contrast media for arteriography, Professor Fontaine plumped for Thorotrast, which was the only substance that he knew which gave an exact picture of the arterial tree without inducing spasm, a spasm which might be dangerous in a limb to which the arterial supply was already precarious. Uroselectan was to be particularly avoided in such cases as its injection might precipitate gangrene. He had used Thorotrast in over 1,700 examinations and had encountered no clinical disability, although in eight cases in which there had been repeated examinations using more than 100 ml. of Thorotrast in all, the liver and spleen were radio-opaque many years later. One such case died of carcinoma of the rectum ten years after the Thorotrast examination, and no histological abnormality could be detected in either liver or spleen.

Asked about venograms in venous thrombosis he said that these were employed routinely, but there were great difficulties in interpretation. He regarded these cases as surgical emergencies, and recommended immediate removal of the clot after localisation. It was gathered that venograms had been practically discarded in the States because of this difficulty.

(ii) Chronic obstruction.

Clinically this was divided into four stages :—

1. The symptomless phase.
2. The stage of intermittent claudication.
3. The stage of 'rest pain.'
4. Gangrene.

Circulation was carried on largely by means of collaterals and these were of two types, direct collaterals which were sparse, and collaterals via muscle branches which were richly distributed ; thus in blockage of the femoral artery, around which there were many muscles, the collateral circulation was good ; in blockage of the popliteal artery, where there were few muscles, the circulation was poor. The efficiency of the collateral circulation depended upon seven factors :—

1. The height of the block.
2. The length of the block.
3. The condition of the muscles.
4. The condition of the veins.
5. The vasomotor state (?).
6. The state of the heart.
7. The rapidity with which the block came on.

To which Professor Fontaine might have added :

8. The hæmoglobin level.

Treatment was considered and Professor Fontaine explained how in stages 2 and 3 (above) sympathectomy had been the great standby, but only 40 per cent. of cases were improved by this means. Cid dos Santos therefore recommended embolectomy in early cases ; or, in cases where the clot had become organised to the vessel wall, removal of clot and intima—thrombo-arteriectomy ! This method was now practised through one long incision, and demanded heparinisation of the patient up to a clotting time of 60 minutes. Professor Fontaine had performed 60 operations of this type with one death from heparin bleeding into the retro-peritoneal tissues, the site of a previous sympathectomy, and only 20 of these cases showed on arteriography that the vessel had remained patent for as long as three months.

He therefore now practised removal of the diseased artery with substitution of a vein graft either from the saphenous or the femoral veins after precise localisation of the block by arteriography. The patient was not heparinised in this operation because of the fear of bleeding, and a vein graft up to 35 cm. in length had been successfully grafted. In 20 cases so treated, 3 had developed a thrombosis at the site of the graft, but 17 still possessed a patent arterial channel six months later as revealed by arteriography.

Professor Fontaine concluded by saying that he did not think heterogenous grafts were safe although we had previously listened to a paper by Dr. Oudot of Paris in which he described three successful cases of heterogenous vein graft from dog to man.

2. EXPERIMENTAL.

At a meeting of the Halsted Club in Philadelphia, whither Dr. Blalock and I repaired one Friday and Saturday we saw an ingenious device for the continuous recording of intra-arterial pressure. A hollow tube made of polyvinal was drawn out sufficiently finely to be threaded into a hypodermic needle. The latter so loaded, was inserted into the brachial artery at the bend of the elbow and then withdrawn around the capillary tube which was left in situ. The caliber of this tube was such that virtually no interchange of material took place between the lumen of the tube, which was kept full of citrate, and the lumen of the artery, so that there was no tendency for fibrin deposit within the former. Nevertheless, the pressure changes transmitted up the tube were made to impinge on a delicate tambour which constituted one plate of a condenser system. Increased tension approximated this plate to its fellow and so altered the current of electricity circulating through the condenser system. These electrical changes were stepped up and recorded on a revolving drum, so that a continuous reading was obtained.

The Surgical Department at the Hopkins is fortunate in having attached to it a whole-time physiologist in the person of Dr. Bing. In his department all the physiological studies on the congenital hearts are carried out, and particular attention is now being paid to the work performed by the heart under different physiological circumstances and in various congenital abnormalities. The method is to compare coronary arterial blood with blood coming from the coronary sinus, using nitrous oxide as an indicator. The nitrous oxide content of the blood in the coronary arteries is the same as that of the arterial blood elsewhere and is readily determined, but to estimate the nitrous oxide in the coronary sinus demands a difficult technique of manipulation of an intracardiac catheter, introduced through the saphenous vein so that it can be persuaded to enter the coronary sinus from where a sample of blood is withdrawn. The catheter must not enter the inferior vena cava nor the right ventricle, both communicating with the right auricle by large apertures, and very inviting to the catheter tip. Progress is controlled by fluoroscopy, and also by the onset of fibrillation when the catheter passes by mistake through the tricuspid valve. That practical results of great value are being obtained by this technique argues a very high standard of performance.

The major part of the experimental work on cardio-vascular surgery, however, is carried out in the Hunterian Laboratory or as it is known colloquially, 'the dog house.' There for two years Dr. Blalock worked out the details of his " blue-baby " operation, and it is quite obvious that very few advances in this branch of surgery can be carried out without the opportunities which such a laboratory provides. It is imperative that when the new Guy's is built, if not before, opportunities of this type must be afforded to Guy's surgeons if we are to keep our place in the first rank of European Hospitals. It might be a fitting return compliment if this laboratory, when it is built, were called " The Halsted Laboratory."

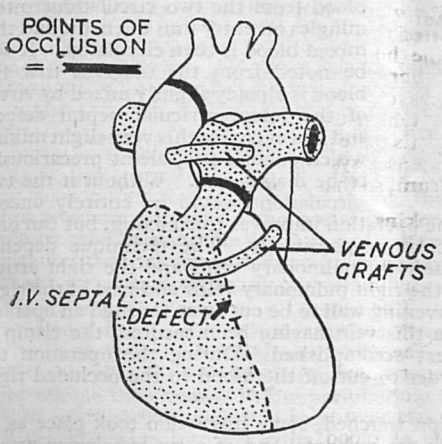
But to return to the ' dog house,' this is a separate building, constructed under the ægis of the late Dr. Cushing, which is fully equipped with a large operating room containing six operating tables, laboratories, and kennels for the accommodation of some fifty animals. Operations are carried out with the same aseptic ritual as in the hospital theatres and the standard of performance is truly superb. The senior laboratory attendant, Vivian Thomas, or just " Vivian " as he is known affectionately throughout Baltimore, is one of the finest technicians in the United States, and many young Hopkins surgeons must owe much of their technical excellence to the training which Vivian bestowed upon them in their early years. That he is also universally in demand as a cocktail mixer at all Hopkins festivities attests to the variety of his achievements !

The dogs are given morphia pre-operatively—a procedure which often acts as an effective emetic, and they are then induced with open ether. As soon as they are ' under ' and, always if the chest cavity is to be opened, an intratracheal tube is inserted, around which there is an occlusive balloon. This closed system is then connected to an automatic respiratory anæsthetic apparatus, devised by Vivian, whereby artificial respiration with an ether mixture is maintained. This apparatus consists essentially of one hollow cylinder rotating within another. The inner cylinder has a hole in its wall and this hole, as it rotates, causes the intratracheal tube to communicate alternately with an ether mixture under pressure, and the atmospheric air so that, by keeping the

revolutions at about 40 per minute, the dog breathes in and out naturally and effectively at this rate.

After shaving and sterilising the skin, the dog is draped and the operation begins. At the conclusion the skin is sutured with continuous silk, and the part again painted with iodine solution. No dressing is applied and the dog usually removes his own stitch in five or six days.

Much time was spent in this laboratory and the most interesting series of experiments was witnessed.



(Fig. 3)

In one an endeavour was being made to see how far it was possible to use free vein grafts to connect the right and left sides of the heart. Vein grafts were inserted between the aorta and the pulmonary artery at the sites indicated (Fig. 3), and so reproduced in essence the clinical condition of transposition of the vessels, so that the mechanics of the transposed circulation could be studied at the same time testing the value of cardiac vein grafts.

In another experiment the possibilities of revascularisation of the heart after coronary occlusion were being investigated in the manner of Claud Beck. The carotid artery was anastomosed to the coronary sinus after the latter had been ligatured proximally to prevent the arterial blood simply running into the right auricle. It was hoped that the arterial blood would then flow retrogradely into the radicles of the coronary vein and so nourish the heart muscle. To test this the coronary artery was subsequently ligated and an absence of infarctation seemed to prove the value of this measure. It was then found, however, that the heart muscle did not necessarily infarct after ligature of the coronary artery even if the previous anastomosis had thrombosed, and when I left this curious finding was being further investigated by the group concerned. Perhaps, they said, simple ligature of the coronary sinus was sufficient to prevent the infarction, perhaps on the other hand they said, it was something quite different.

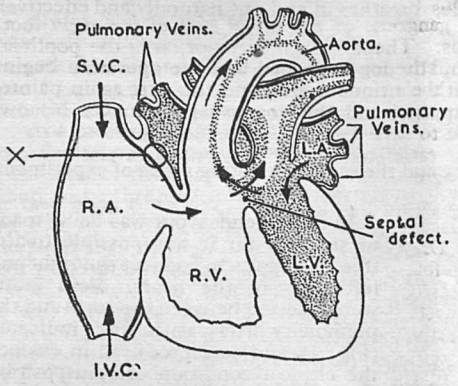
In another experiment some Interns were removing the carotid bifurcation together with the carotid sinus in order to study experimental hypertension; and in yet another the pulmonary artery was being anastomosed to the pulmonary vein, to reproduce for study the mechanics of the pulmonary circulation in arteriovenous aneurysm of the lung (*v.s.*).

Such was the type of work to be seen daily in the Hunterian laboratory. This work was being performed not only by Dr. Hanlon who was in charge of a laboratory, but by the Residents and Interns, and also by the students, who were encouraged to spend a few hours a week in the 'dog house' working at some problem which had suggested itself to them or to which they had been prompted. We shall see later how experimental work of great interest was being carried out, in other than the cardio-vascular field, by fourth year students.

3. OPERATIVE.

(*a*) Heart and Great Vessels. All the cardiac operations which I saw, with the exception of those for pulmonary stenosis and patent ductus, which were carried out by the Assistant Residents, were performed by Dr. Blalock and constituted an interesting cross-section of modern cardiac surgery.

Two operations for coarctation of the aorta were witnessed. The operation proceeded according to the standard technique and about half an inch of the aorta containing a pin-point stenosis was resected with end-to-end reconstruction. In each case monstrous collaterals interfered with the dissection, and in one case caused hæmorrhage which had to be controlled with 'Gelfoam.'



(Fig. 4)

Two cases of transposition of the vessels (Fig. 4) were operated on during my visit. The operation is fully described in the literature (Blalock, A., Hanlon, C. R., Surg. Gyn. Obstet. 1948, Vol. 87, 183), and does not, as these cases go, appear to be too difficult. The essence of the operation is to make an interatrial septal defect so that the blood from the two circulations intermingles on entry into the heart and this mixed blood is then circulated. It will be noted from the diagram that the blood is already slightly mixed by virtue of the interventricular septal defect, and it is of course this very slight mixing which enables life, albeit precariously, to be maintained. Without it the two circulations would be entirely unconnected and life therefore impossible. The operation improves this mixing, but can only effect an approximation to normal circulatory physiology. The technique depends upon the fortuitous circumstance that the right pulmonary veins and the right article have a common wall at X. Occlusion of the right pulmonary veins and part of the right auricle in a special clamp allows this intervening wall to be cut away through an opening in the pulmonary vein. The opening in this vein having been secured, the clamp is removed and the interatrial septal defect accomplished. During the operation the right pulmonary artery is occluded in order to cut off the blood to the occluded right pulmonary vein.

At the conclusion of the first operation watched, some discussion took place as to whether, at the same time, to anastomose the proximal end of a cut subclavian artery to the distal end of a cut superior pulmonary artery, and so lead to an even greater flow of venous blood (from the subclavian artery) into the lungs. The child, however, was not considered in a fit condition for a further elaborate procedure and the operation was concluded. All these cases are desperately ill with a hopeless prognosis, and are perhaps the worst with which Dr. Blalock has to deal, it is therefore gratifying that out of the first ten cases submitted to this procedure, four have left the hospital greatly improved.

Operations were also performed for constrictive pericarditis and 'Ebstein's Syndrome.' The former was performed through a median sternotomy and an excellent exposure was obtained. In the latter condition the tricuspid valves are sunk into the right ventricle and so grossly inefficient that enormous dilatation takes place of this latter cavity which is never completely emptied, angiocardiograms showing the dye to remain for a considerable length of time within the football-like shadow of the right ventricle. No direct attack was contemplated on the tricuspid valve, but it was thought that a pulmonary stenosis might co-exist. In this, however, the first case of 'Ebstein's Syndrome' ever to be submitted to operation, the pressure in the pulmonary artery was high and nothing could be done. The sight of this enormous pulsating right ventricle was one which will never be forgotten.

(*b*) Sympathectomies in cardio-vascular diseases.

Lumbar sympathectomy for peripheral vascular disease of the leg is performed here much as we do it at Guy's except that the approach is more lateral. Pre-operative and post-operative studies are made of skin resistance, and reliance is placed on these tests alone, both in indicating the necessity for sympathectomy, and in judging the completeness of the operation subsequently; furthermore silver clips are placed at the upper and lower levels of sympathetic section so that X-ray photographs post-operatively reveal the extent of anatomical denervation. Chronic leg ulcers are subjected to this procedure, and the one which I saw, and somewhat doubtingly did, healed surprisingly rapidly.

Sympathectomy for hypertension is performed by resection of the 8th and the 11th ribs. The approach is extra-pleural and aims at removing T.7 to L.3 inclusive. Silver clips are used extensively to control the small bleeding vessels running along the grey rami communicantes, which often cause annoying oozing, and the patient is laid prone with the operator standing on the side from which the chain is to be removed. A lateral tilting table is of great benefit in this operation.

(*c*) General cardio-vascular operations.

A woman aged 42 was brought in with gangrene of the distal half of the right foot, from the story, apparently due to embolus. There was good pulsation in the popliteal artery of this side, but the dorsalis pedis and the medial malleolar pulsations were absent. The opposite limb had been amputated at the site of election below the knee and I was interested to see a Syme's amputation being performed upon the right side in what might be regarded as a desperate attempt to save for the patient some natural weight-bearing part. Certainly the flaps healed satisfactorily and I await with the greatest interest a subsequent report upon her progress.

The problem of portal hypertension is one which naturally exercises a good deal of attention at the Hopkins, and before discussing the operative indications it will be helpful to describe a paper read to us by Dr. Gray Pearson dealing with liver function after shunt operations. Dr. Gray Pearson found that liver function, as measured by the bromsulphthalein test (B.S.P.) was depressed after an Eck fistula (porto-caval shunt). He found that this depression was aggravated by splenectomy and suggested that it might, in a large measure, be due to defective oxygenation of the liver cells for which the portal vein might normally be partly responsible, a hypothesis which, as one commentator declared, would explain much of the liver failure in portal cirrhosis. Dr. Gray Pearson therefore anastomosed in dogs the coeliac axis, distal to its hepatic branch, to the proximal cut end of the portal vein at the same time as he produced his Eck fistula by anastomosing the distal end of the portal vein to the vena cava. In these circumstances the liver function was materially improved and the B.S.P. had all disappeared from the circulation within 20 minutes.

Dr. Rienhoff, whom we all remember with such affection, commenting on this paper agreed that in cirrhosis the cause of liver failure might well be deficient oxygen, but he went further and suggested that owing to the obstruction of the capillary bed by fibrosis within the liver lobule in such cases, the hepatic artery and portal vein radicles might mingle their bloods in the periphery of the liver lobule and the blood from the hepatic artery, being unable to escape into its natural capillary bed, would be thrown back under tension into the portal radicles, thus increasing the general portal hypertension. In a case of cirrhosis with ascites, he said, he had three years ago ligatured the main hepatic artery of a bartender, who had had to be tapped continually. Since the operation no tapping had been necessary and the bartender was, if not in perfect health, well—in health!

I watched Dr. Blalock perform one operation for portal hypertension, but unfortunately this could not be completed. The circumstances were these. A young girl of nineteen had been having repeated hæmatemases from œsophageal varices; the cause was thought to have been an umbilical infection at birth with spreading thrombosis of the umbilical vein to the portal system. As the liver function tests were normal, it was assumed (according to the general rule) that the portal vein itself was the site of the obstruction, at least that the obstruction was extra-hepatic; and it was therefore decided to anastomose the splenic vein to the renal vein. At this operation, however, vascular adhesions were so formidable that the operation was concluded with the splenectomy and no anastomosis was carried out. Before the second operation discussions took place as to whether porto-caval shunt was feasable. Blakemore had stated that where liver function tests were normal, lieno-renal anastomosis was the operation of choice, since the portal vein was probably the site of the obstruction and might even be thrombosed. Furthermore, where the spleen had been removed, as in this case, normal liver function was an indication to use the superior mesenteric vein for the anastomosis instead of the portal. However, it was here decided to explore the possibility of the easier and more satisfactory portal anastomosis first. The whole length of the eleventh rib was removed and an excellent exposure obtained through a combined thoraco-abdominal approach. The unfavourable prognostications were, however, only too obviously justified: no blood could be withdrawn by a syringe and needle from the site where the portal vein should have been. It was then decided to look for the superior mesenteric vein by turning the duodenum medially, but this structure was bound down by areolar tissue through which coursed venous collaterals of such size and complexity as to constitute a veritable aneurysm. It was decided therefore that in approaching the superior mesenteric vein the hæmorrhage would be very severe, and that furthermore, many functioning collaterals would have to be sacrificed in order to secure an artificial anastomosis which might or might not function. The procedure was therefore regretfully abandoned and, instead, the omentum was implanted into the subcutaneous tissue in the hope that at least something might be effected.

(To be continued)

Obituary

CHARLES MORLEY WENYON, C.M.G., C.B.E., M.B., B.S., B.Sc., F.R.S.

DR. C. M. WENYON died at his home in North London on the 24th October, 1948. Although his final illness lasted only a few days, he had been in indifferent health for some considerable time.

Wenyon was born in Liverpool in 1878 and spent most of his boyhood in China. He returned home in 1892 and, after some years at school, studied first at Leeds University and later in London at University College and at Guy's Hospital. Shortly after qualifying he came under the notice of Sir Patrick Manson and was appointed Protozoologist to the London School of Tropical Medicine, thus beginning the special studies to which he devoted the rest of his life. In the next few years he visited and worked in Sudan, Mesopotamia, Syria and Malta. In 1914 he joined the Wellcome Bureau of Scientific Research as Director of Research in the Tropics but during World War I was seconded to the Army, where he filled various research and consultant appointments in the Near East. In 1924 he became Director-in-Chief of the Wellcome Bureau of Scientific Research in succession to the late Sir Andrew Balfour and held this appointment until 1944. Thereafter he acted as Consultant in Tropical Diseases to the Wellcome Foundation and was still in harness at the onset of his final illness. He had a long connection with the Royal Society of Tropical Medicine and Hygiene, being for 25 years Honorary Secretary, and then President. His unflagging devotion to the interests of this Society was largely instrumental in bringing it to the prosperous position it now occupies.

Among the many honours awarded to Wenyon were the C.M.G. and C.B.E., the Theobald Smith Gold Medal and the Manson Medal. He was a Fellow of the Royal Society and an Honorary Fellow of the Royal Society of Medicine, an Officer of the Legion of Honour and an Honorary Life Member of the New York Academy of Sciences.

Wenyon's contributions to Protozoology were many and diverse. His studies of the protozoa found in the human intestine were of fundamental importance. His identification of *Endolimax nana* and the cysts of *Iodamœba butschlii*, together with his clear differentiation of *Entamœba coli* and *Entamœba histolytica*, made possible the accurate microscopical diagnosis of amœbic dysentery. His early work in the transmission of cutaneous leishmaniasis led to the discovery of much of the evidence which finally incriminated the sandfly as the vector. He described the development of coccidium in man and added to the existing knowledge of trypanosomes, plasmodia and many other parasitic protozoa. In 1926 he published "Protozoology," a monumental tome rich in original observations, which is still the leading work of reference on this subject.

Wenyon's outstanding characteristics were his vitality, his sincerity and his intrinsic kindliness. He was the best of good companions, full of sparkle and wit and fun, a raconteur who quickly became the central figure in any group. In professional matters his broad outlook, his sound judgment and his shrewd wisdom lent much value to his opinion, and in later years his laboratory had the characters of a shrine to which came a constant stream of visitors from all corners of the globe, seeking the help and advice which were always freely given. His loss is a very real one to those who had the privilege of working with him.

Christmas, 1948

The following has been sent to us by the Hospital Chaplain :—

Large numbers of people at Guy's celebrated Christmas with all the traditional services of praise and thanksgiving which alone can express the true meaning of the Nativity of Jesus Christ.

The Service of Nine Lessons and Carols was held on the Monday of Christmas week in the Chapel. The music was by a choir of members of the Hospital and the lessons read by Hospital representatives and the Provost of Southwark. The Superintendent was unfortunately unable to be present to read owing to an urgent call away.

The Festival's greatest moment was the Procession, Blessing of the Crib and Midnight Mass, which was attended by so large a number of the Staff that the Chapel was crowded.

Christmas morning began with the nurses singing carols in the wards, then a further celebration of Holy Communion was held in Chapel. Throughout the festival services were held in every ward of the Hospital, and the Cribs blessed in the Children's wards. Thus both Staff and patients were able, to the fullest extent, to join in with all Christian people the world over in giving thanks for the Birthday of the Son of God.

Dr. Keith Simpson's
Forensic Medicine Section of the Gordon Museum
By the late Mr. ROBERT BURNS.

A murderer's banes, in gibbet-airns;
Two span-lang, wee, unchristen'd bairns;
A thief new-cutted frae a rape—
Wi' his last gasp his gab did gape;
Five tomahawks wi' bluid red-rusted;
Five scymitars wi' murder crusted;
Seven gallows pins; three hangman's whittles;
A raw o' weel seal'd Doctor's bottles.
A garter which a babe had strangled;
A knife a father's throat had mangled—
Whom his ain son o' life bereft—
The grey-hairs yet stack to the heft;
Wi' mair of horrible and awefu'
Which even to name wad be unlawfu'.

For the benefit of the Sassenach.
Airns—Irons. Gab-Mouth. Whittles—Knives.

J.W.M.

OVERHEARD IN FRONT SURGERY—CHRISTMAS EVE, 1948.

Patient, undergoing repairs to scalp wounds :—

" Oh doctor, I feel much better now. It's good to know I'm in Bart's."

OVERHEARD AT CHRISTMAS DINNER.

Junior Probationer, to Houseman insisting on her taking further refreshment :—

" Oh no, please Mr. J., because Sister says I musn't get giggly ! "

FREE-MARTINS.

Discussion arose the other day about Free-martins. This is an interesting phenomenon encountered in Dairy Husbandry, in which the female of twins of opposite sexes is completely sterile. It would appear that in not more than one in every sixteen such births, the heifer is capable of breeding. This figure is a very rough estimate, but is sometimes quoted. The fœtal circulation of twins in the bovine is a common one, and as the gonads of the male fœtus develop earlier than those of the opposite sex, the hormones secreted by the former have a strong depressing influence upon the development of the female genitalia. In such heifers, the development of the body and horns of the uterus is extremely rudimentary. There is generally no cervix and the vaginal cavity is small and often occluded at its anterior end by an almost complete hymen.

Reviews

Modern Methods of Infant Management. Edited by W. R. F. COLLIS. 1st Edn. William Heinemann. *Price* 17*s.* 6*d.*

THIS book details the methods employed in The Rotunda Hospital for the minimisation of the loss of neonatal life. Some odd attitudes of mind are expressed, together with not a few practices which we find difficult to accept. Artificial feeding, for example, is based entirely on home modifications of raw cow's milk. The chapters on ante-natal care and the management of labour, in their present form, are quite out of place. Here and elsewhere, the book lacks balance.

H.A.R.

Obstetrics and Gynæcology. By BEATRICE M. WILMOTT DOBBIE. H. K. Lewis *Price* 20*s.*

THIS book describes itself as a "synoptic guide to treatment." It is small (pp. 358) with a few moderate illustrations, and is insufficient for the undergraduate. But for the recently qualified doctor, disappearing into the woods of general practice, with his obstetric appointment some way behind him, or the ex-serviceman in a similar predicament, it can be recommended as a book which will link up the principles which he once learnt in the more ideal surroundings of a general hospital with the practices in which he will have to indulge in the surgery and "the bedroom by candle-light." Although a few views expressed are unusual, in general the author has managed to put first things first and has followed the orthodox.

H.A.R.

The Queen Charlotte's Textbook of Obstetrics. By MEMBERS OF THE CLINICAL STAFF OF THE HOSPITAL. 7th Edn. Churchill. *Price* 28*s.*

"THE whole book has been revised to bring the text into line with the methods of Obstetrics as practised at Queen Charlotte's Hospital to-day." No text book could carry a better seal of its authenticity. It is a large volume, suitable for the student who already knows his elementary obstetrics, for the candidate up for his diploma or membership, or, for the practitioner, as a reference book. For the dresser doing his obstetric appointment, unless he is more than ordinarily interested in the subject, it is a little too much of a good thing.

The sections on Toxæmias and Puerperal Infections are outstanding, and throughout one can clearly differentiate between what is advocated, and what might be done.

H.A.R.

A Textbook of Gynæcology. By WILFRED SHAW. 5th Edn. Churchill. *Price* 25*s.*

THIS well-known textbook has much to commend it, excellent microphotographs, good diagrams and plenty of each, while the sections on anatomy and physiology, so essential a part of any such book, are most thorough and most readable.

But in places views which are not only inacceptable to examiners, but which are regarded by such people as bad mistakes, are propounded, while to describe colposcopic examination as one of the most important advances in gynæcology shows a lack of balance which is not confined to this remark only.

H.A.R.

Physical Signs in Clinical Surgery—Part II. By HAMILTON BAILEY. 11th Edn. John Wright & Sons. *Price* 8*s.* 6*d.*

THE recently published (and reviewed) Part I dealt with basic physical signs, general principles, localized swellings, local inflammation, ulcers and sinuses, and then continued with regional sections on the mouth, salivary glands, face and jaws, the head and the ear. Part II demonstrates equally well the signs in the neck, the thyroid, the breast and axillary lymph nodes, the thorax, upper limb, hernia and the lymphatics of the groin.

R.

Physical Signs in Clinical Surgery.—Part III. By HAMILTON BAILEY. 11th Edn. John Wright & Sons. *Price* 8*s.* 6*d.*

THIS, the penultimate part, deals with non-acute abdominal conditions, rectal and vaginal examinations, the urinary tract, the male generative organs and some common acute conditions in the abdomen.

R.

Elementary Atlas of Cardiology. By H. WALLACE-JONES, E. NOBLE CHAMBERLAIN and E. L. RUBIN. John Wright & Sons. *Price* 12*s.* 6*d.*

THIS excellent little book is written for medical students and practitioners who wish to know the essential elements of electrocardiography. It is written in a concise style, and only includes references to the simple E.C.G. variants likely to be encountered in every-day practice. It is not a comprehensive text-book for the cardiologist.

The second half of the book is devoted to a series of X-ray plates, with explanatory diagrams. The pictures are chosen to show the appearance of a sound heart on X-ray, and those variations which may commonly occur. This book should do much to reassure those who have avoided this subject and dismissed it as advanced medicine.

K.E.

The Modern Management of Gastric and Duodenal Ulcer. By COXON DULLER. Livingstone. *Price* 20*s.*

ALTHOUGH a wide range of subject matter is covered in this book, much of its value is lost by its very comprehensiveness. The article, in an attempt to appear unbiased, has excluded such a mass of opinions and figures, that the reader is swamped with information, much of it contradictory. To those with considerable experience of the subject the book may be recommended, but it does little to clarify what is still a highly debatable subject—the treatment of peptic ulcer.

K.E.

Sport

HOCKEY

GUY'S *v.* METROPOLITAN POLICE

at Imber Court. Won 4—2.
11th December, 1948.

Having drawn and lost in the last two seasons the Hospital were eager to turn the tables on one of their strongest rivals. But to pass on such a wet, heavy pitch meant hitting very hard, and there was often an element of luck in ball-control.

Guy's were on the attack from the start. The first goal was made, after ten minutes, by D. Blake who reverse-passed very well in the circle, for S. Earl to score from close in. C. Opie cleverly followed with the second a few minutes later, and the Hospital appeared to rest content. But the Police rallied, and, with a determination so characteristic of another role, stormed the Hospital goal for ten minutes. Two goals came quickly, the first from the right wing who flashed in a powerful drive from an acute angle. The second was converted from a short corner. There would have been a third had F. Walker not bravely taken the ball on his chest.

The second half was a ding-dong battle with both defences shining in strong clearances. In these, both N. Parker and W. Mackey seemed to excel. Then, with five minutes to go and both sides tiring, the home defence was caught on the wrong foot and two goals were scored for Guy's. Both were the result of passes by R. Hodson, outside right, and D. Blake netted the ball each time.

Team : F. Walker, G. Danford, N. Parker, C. Robinson, E. A. Murray (Capt.), W. Mackey, D. V. Duckworth, D. Blake, S. Earl, C. Opie, R. Hodson.

GUY'S *v.* WEST HERTS.

at Watford. Won 2—1.
18th December, 1948.

The fixture promised a keen struggle but a heavy pitch lowered the standard of play. Guy's, starting with only ten men, were unable to play an open game. Soon after the arrival of the eleventh man, S. Earl put Guy's in the lead by drawing the goalkeeper to push the ball into the net. West Herts equalised in a similar fashion, the state of the ground putting both goalkeepers at a disadvantage.

The Hospital pressed hard in the second half, well supported by the defensive play of N. Parker. The attacks, though ponderous, were rewarded by a goal which gave Guy's the lead they retained till the final whistle.

As this match concluded the first half of the season's Hockey, it is worth taking stock of the Club's 1st XI record so far. Of the 10 matches played, 9 have been won and 1 drawn. This is certainly a post-war record and reflects a standard of Hockey which, we trust, will enable us to retain the Inter-Hospitals Cup for 1948–49.

Team : F. Walker, P. Kapff, N. Parker, N. Price, E. A. Murray (Capt.), D. McGill, A. Blower, D. Blake, S. Earl, C. Opie, R. Hodson.

ASSOCIATION FOOTBALL

SOUTHERN AMATEUR LEAGUE

GUY'S *v.* KEW ASSOCIATION

at H.O.P. Won 3—0.
18th December, 1948.

Guy's found themselves slightly weakened by the early commencement of the Xmas vacation, but nevertheless managed to wind-up the term with a convincing victory at the hands of Kew Association.

Sturdy quickly put Guy's ahead with a well-taken goal after some fine approach work. We continued to play good football and it came as no surprise when Skaith accepted a pass from Whitaker playing in the unaccustomed position of left wing to make it 2—0.

Kew resorted to playing the off-side game which seemed to disturb the harmony of the Guy's attack and for a period just prior to half-time the home defence was hard put to keep their goal intact.

Guy's continued to press continuously throughout the second half but it was left to Skipper Matthews to beat the off-side trap by coming through on his own to score.

Young played yet another magnificent game at centre-half; both wing halves, Matthews and Swift, gave their forwards many opportunities, whilst Sturdy was forever striving hard to swell the score.

Team : A. Fearn, D. Lipington, P. J. Holloway, D. G. Matthews, F. Young, P. A. Swift, J. Whylie, J. C. Leckie, R. Skaith, D. E. Sturdy, A. H. Whitaker.

The following Guy's men assisted United Hospitals in both the games mentioned below: D. Lipington, F. Young, D. G. Matthews, J. C. Leckie, A. G. Prince.

U.H. *v.* A.F.A. XI. at Barnet on 8th December, 1948.—U.H. *won 5 goals to 2.*

U.H. *v.* Southern Amateur League XI. at H.O.P. on 15th December, 1948.—a draw 4—4.

Results in Southern Amateur League during winter term: Played 8, won 3, drawn 1, lost 4. Goals for 16, goals against 17. Points 7.

GUY'S *v.* ALLEYN OLD BOYS

at H.O.P. Lost 0—3.
Saturday, 8th January, 1949.

Guy's started their New Year's fixtures most inauspiciously, and were very disappointing to lose to Alleyn Old Boys 0—3.

At no time was the forward line together and the enforced switching of Leckie to the defence following a pulled muscle injury to Holloway, deprived Guy's of what threatened to be their most dangerous forward.

The Old Boys were the better team throughout, mainly because they were faster on the ball. They played with more enthusiasm, and their inside forwards and half-backs opened up the game to better advantage.

Guy's certainly missed the commanding presence of Young at centre-half, although Fearn in goal and Lipington played splendidly. Leckie also proved his versatility when he took over the pivotal position. Score at half-time 0—1.

Team : A. Fearn, D. Lipington, P. J. Holloway, D. G. Matthews (Capt.), J. Whylie, P. A. Swift, J. C. Leckie, N. I. Lewis, R. Skaith, D. E. Sturdy, A. H. Whitaker.

MOUNTAINEERING

Six months ago we published a notice, setting out the aims of the Mountaineering Association which are to provide adequate training in mountain-craft through permanent schools and interim training courses and, indirectly, to reduce the number of tragic accidents on mountains. This year the Association is arranging a number of such courses and is seeking to raise funds for the building of the first permanent mountaineering training school in this country.

These training facilities are available to all, and the Association is particularly concerned to see that young people of all classes take full advantage of them. The tuition is on a non-profit-making basis and the scheme has the support, among others, of the Rt. Hon. the Lord Pakenham, the Rt. Hon. Sir Norman Birkett, P.C., and the Hon. Quintin Hogg, M.P.

Those interested in furthering these objects and facilities are invited to communicate with J. E. B. Wright, Esq., 1, Kildare Gardens, W.2.

BOXING TOURNAMENT

Applications for tickets may now be received for the Boxing Tournament to be held at Seymour Hall on Tuesday, February 22nd, 1949, when Guy's will meet St. Mary's in an inter-club match. Special contests are being arranged between well-known boxers from prominent amateur clubs, and there will be an open Novices Competition.

Profits will go to the funds of the Pavy Gymnasium, and a special appeal is made to all Guy's Men to support the venture in an effort to add to the funds of one of the most deserving of Guy's institutions. Price of tickets are 12*s.* 6*d.*, 10*s.*, 7*s.* 6*d.*, 5*s.* and 2*s.* 6*d.*, all numbered and reserved. Applications should be sent to Boxing Tournament, Counting House, Guy's Hospital, S.E.1. (Hop. 3334.)

Sport and Hospital Information

WAR MEMORIAL APPEAL

Donations received up to 31st December, 1948

£10 10*s.*—Foreman, J. £5 5*s.*—Nicolai, F. A.; Peatfield, F. H. W. £5.—Lewis, T. L. T.; Moiser, B. £3 3*s.*—Herbert, Prof. W. E.; Muir Smith, L.; Williams, H. K. £3.—Fitch, Lt.-Col. K. S. £2 2*s.*—Bailey, W. O.; Doran, B. J.; Gardiner, P. A.; Min Sein, Lt.-Col. Peregrine; R.L.; Van't Hoff, W.; Rosenberg, I. £2.—Irish, N. W. £1 1*s.*—Beales, C. Maxwell; Blaxter, P. L.; Borghys, P.; Brown, G.; Morwent, A.; Corker, R. H.; Dresing, Maj. H. G.; Flitcroft, J. H.; Fuller, F. H.; Jones, I. O.; Jones, M. E. (Miss); Joynt, M. C.; Le Clezio, E.; O'Donoghue, R.; Pearson, E. Z. C.; Richmond, J. H.; Starte, A. E.; Willett, J. E. £1.—Annesley, F. D.; Bowdler, Miss F.; Martin, J. K. 10*s.*—Wong, B. L. Evan. 5*s.*—Leach, Miss A.

Total .. £1,625 2*s.* 8*d.*

NOTICE

ANÆSTHETIC REGISTRAR

Applications are invited for the appointment of Anæsthetic Registrar (whole-time). Appointment to start as soon as possible and will date until 30th September, 1949, in the first instance. Salary £600 per annum plus superannuation, plus family allowance on the School's share of the salary (half). Forms of application obtainable from the Medical School Office and should be submitted to reach the Dean not later than 27th January, 1949.

PASS LIST

CONJOINT BOARD

FIRST EXAMINATION.

December, 1948.

Anatomy.

R. L. G. Thornton

Physiology.

J. K. Blackwell	M. N. Halamandres
H. G. Carr	R. L. G. Thornton

Pharmacology.

J. H. Bailey	R. C. Michell
H. M. Baird	R. C. Nauth-Misir
A. G. Blyth	R. J. Powell
A. E. R. Buckle	A. M. Reader
J. C. Camac	I. Rocker
B. I. Copeland	H. Schapira
M. J. Craft	P. R. Sowerby
R. C. Greenberg	D. E. Sturdy
P. D. Harvey	E. M. Sycamore
E. T. J. Jones	B. Taylor
G. M. Karpusheff	M. G. Thompson
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M. J. R. Mackrill	R. A. J. Williams

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

FIRST EXAMINATION.

December, 1948.

Anatomy and Physiology.

R. G. K. Burston S. Shindler

Special Anatomy and Physiology.

R. R. Alsop	D. A. Holford
M. E. S. Bathurst	P. R. Jones
R. G. K. Burston	W. H. Legg
A. E. Bond	W. C. Porter
R. M. Clarke	F. Roth
A. G. Gapper	H. G. P. Ryan
D. C. L. Grigsby	S. Shindler
P. D. V. Harrett	J. J. F. Staub
H. R. Harvey	C. A. P. Steele

Dental Materials.

A. G. Gapper	D. M. J. Lyons
K. F. C. Muncey	R. B. Whalley

Dental Mechanics.

R. C. Bret-Day	R. E. W. Pearce
J. G. G. Dixon	W. C. Porter
A. G. Gapper	T. M. Smith
J. C. Leckie	R. B. Whalley
F. R. B. Mathias	

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P. Maxwell Stephens, L.D.S., R.C.S., 60, Portland Place, W.1. (Tel.: Langham 4246/47).

H. Gordon Ryder, L.D.S., Wickham, Main Road, Wakatu, Nelson, New Zealand.

PAPERS BY GUY'S MEN

Barber, H. W. Schamberg's Disease. *Proc. Roy. Soc. Med.*, 1948, **41**, 754.

Barber, H. W., and Erskine, D. Parapsoriasis en Plaques Treated with Calciferol. *Proc. Roy. Soc. Med.*, 1948, **41**, 755.

Evans, P. R. C., and Another. A case of Tetanus treated with d-Tubocurarine Chloride. *Brit. Med. J.*, 1948, ii, 1022.

Hills, T. H. Note on an apparatus for angio-cardiography. *British Journal of Radiology*, 1948, p. 511.

Jacoby, N. M., and Another. Human Toxoplasmosis in England. *Lancet*, 1948, ii, 926.

P. McG. Moffatt. Anterior Synechiæ following Perforating Injuries. *Proc. Roy. Soc. Med.*, 1948, **41**, 745.

BIRTHS

FILOSE.—On November 18th, 1948, to Audrey (née Stack), wife of Myles Filose—a daughter (Frances Mary).

DEATH

PALMER. — On November 22nd, 1948, at Morningside, Prestbury, near Cheltenham, Harold Thornbury Palmer, M.R.C.S., L.R.C.P. (1902), D.D.M.S., Nigeria (Retired).

Eds. { H.A.R. R. G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

MANY of the proposals made in the so-called "Goodenough Report" of 1944 represented practices in medical education which had been followed at Guy's for some time. Others have been adopted since that date. In particular, clinical departments have been established, each under the guidance of a director or "academic head." Students remain attached to firms as hitherto but the teaching is organised and co-ordinated to a greater extent. The new system is designed presumably to attain the dual objectives stated in the report, namely, to ensure that "undergraduate training is primarily practical in character" and that the "main emphasis should be on the inculcation of fundamental principles and methods rather than the implanting of a mass of purely factual knowledge."

"The organisation of teaching," the report goes on to say, "is likely to be assisted by two other means, which are . . . to hold periodic informal meetings of all teachers . . . and to obtain, regularly, the views of students regarding deficiencies and desirable improvements." The former, no doubt, take place. Student views, however, tend to be somewhat inchoate. That is why the liberty is now taken of drawing attention to certain aspects.

Guy's is renowned and rightly so for the importance attached to practical and clinical work. Every student before qualification gets invaluable and extensive experience with patients in the wards, theatres and out-patient departments. But the fact is that a dire shortage of beds continues to exist. For a medical school of the magnitude of Guy's the minimum bed figure that has been suggested is 950 to 1,000. Admittedly, training in child health is carried out at the Evelina and practical obstetrics are conducted at Farnborough, Pembury and Brighton. In medicine and surgery, nevertheless, facilities are still limited. Is any progress, therefore, being made towards the incorporation of St. Olave's or similar hospitals in the neighbourhood as associated teaching centres?

Secondly, there is a need "for the greater encouragement of the analytical, in contrast to the descriptive, method of approach and for a wider use of the inductive and deductive processes of thought," to quote from the memorandum of the University College Hospital Medical School. No better exponents of this art could be found than the clinicians at Guy's. The student, in fact, has an unprecedented opportunity for seeing at work the finest clinicians in the land. At the same time he has less chance to do things for himself. Not until he goes into practice or, maybe, faces the gentlemen at Queen's Square and elsewhere will he be thrust back on his own resources.

We need not be denied the pearls of wisdom that the experts so generously cast before us. But students must learn for themselves to elicit symptoms and signs and to argue differential diagnosis and treatment. The Physical Society, soon to be revived, provides a valuable yet limited field for such exercises. Further scope is needed. The actual methods of examination should be covered in the preliminary clinical appointment. Thereafter, surely, students should deal with cases on their own initiative, possibly taking advantage of beds belonging to other firms. Discussion among the firm and under the supervision of the registrar should come afterwards. Far better this than for each person to "play the sedulous ape" to the registrar on a case which may well have been taught upon already. No tyro has any difficulty in obtaining the history, recognising the signs or accepting the diagnosis then. In addition, at the more august gatherings, what is against the student providing a "Roman holiday," rather than acting as a mere reader of case notes as he so often does now?

"Spoon-feeding" has never been in favour at Guy's. Let us beware that this *embarras de richesse* in organised teaching does not obviate the need to see and think for oneself.

Ascites

By CHRISTOPHER HARDWICK, M.D.

A Lecture delivered at Guy's Hospital Medical School on Friday, November 26th, 1948.

GENTLEMEN,—Ascites occurs in many conditions. Only too often it is extensive and considerable, so that its diagnosis is easy, and, unfortunately, in the majority of such cases the prognosis is desperate. It can at times be detected in its early stages, and although that is often an important point in the differential diagnosis, still, I think it is true to say that it does not make very much difference to the prognosis. It is largely therefore diagnosis, and to a certain extent, perhaps, management that I wish to consider.

Aetiology.

The fluid is usually clear, straw-coloured; sometimes it is blood-stained. Rarely it is turbid or even milky. The appearance of ascites depends on three factors. First, on the pressure within the capillaries which forces the fluid out into the peritoneal tissues; secondly, on the plasma proteins which are responsible for attracting the fluid back into the lumen of the vessels, and thirdly, upon the permeability of the capillaries. Sometimes one of these factors is to blame. In portal hypertension the pressure within the capillaries is greatly increased. In severe malnutrition—famine œdema, in which there may be ascites—it is almost entirely a question of a deficiency of the protein. In inflammation it is probably the permeability of the capillaries which is at fault. But very often it is a mixture of all three factors, and although one may predominate in a particular case it may be impossible to say which is the factor that is at fault.

You may see ascites in cardiac conditions—in congestive failure, and, more importantly, though more rarely, in constrictive pericarditis. It occurs in renal conditions—in subacute nephritis and also in lipoid nephrosis. It occurs in hepatic conditions—in both acute and chronic hepatitis, and also in those conditions in which there is considerable increase of the portal pressure. It occurs in purely peritoneal conditions where there are malignant deposits throughout the peritoneum and where there is chronic inflammation. It occurs in general disorders—in severe malnutrition. A small quantity collects sometimes in severely anæmic subjects, and there are one or two rare conditions in which it occurs but with which we need not concern ourselves.

Symptoms and Clinical Findings.

As to the symptoms you will, of course, have those of the accompanying condition, whatever it may be, and you will have those produced by the presence of ascites. Sometimes, referable to the ascites itself, will be abdominal discomfort and tightness. Occasionally, if the fluid collects rapidly and there is considerable distension you will get generalised abdominal pain, but that is unusual and most often the patient comes to you with a considerable increase in girth as his only complaint and worrying only slightly about abdominal discomfort or pain. Perhaps he may have also a little swelling of his ankles.

As for the clinical findings, again a general examination of the patient may go a long way towards establishing the diagnosis. When you come to consider the abdomen you take note first of its general appearance. If there is any degree of ascites there will be distension or ballooning of the abdomen, so that the lateral curve is considerably greater than the antero-posterior measurement—fullness in the flank. Then the maximum girth of the abdomen will be at or about the umbilicus and that may be an important point in differential diagnosis.

The two cardinal signs are shifting dullness and a fluid thrill which can be detected if there is any quantity of fluid. To detect shifting dullness, first map out by percussion a dull area in the flank whilst the patient lies on his back, then, keeping the palpating hand in position whilst you roll the patient on to his side, allow time for the fluid to find its way to the lower part of the peritoneal cavity, and then percuss again and a more resonant note will be obtained. If there is inflammation or matting together of the intestines it may be impossible for the fluid to shift and so the sign will not be obtained and that will be a point of significance.

A fluid thrill is also given. You must get a colleague to place the side of his hand on the centre of the patient's abdomen and press it in so as to act as a damper to any vibrations in the abdominal wall, and then any impulses which you feel with your palpating hand must have been transmitted across the peritoneal cavity. Again, a sign of very gross ascites is the sense of dipping that you get when you palpate over the liver. You go down on the liver through a layer of fluid which gives a characteristic sensation.

I have left till last in our appreciation of the clinical findings any mention of the pelvis. This is a very roomy receptacle; it will hold at least a litre of fluid, and if, as so often happens, you examine the patient with the pelvis not the most dependent part, then fluid will be spilt throughout the abdominal cavity where it is difficult to be detected. If, however, you so manœuvre things that the pelvis is the lowest part of the patient and it is full of its litre of fluid, then by examining per rectum you may detect fluid which you might miss if you only felt for it via the abdomen. It is a useful procedure to make a rectal examination of these patients, not in the left lateral position, because in that condition the pelvis spills its contents into the abdominal cavity, but to have the patient lying flat on his back if necessary with a few pillows under his shoulders, so that there is no doubt that the pelvis is the lowest part, and then rectally you may be able to detect fluctuation anteriorly. I grant that it is difficult to appreciate fluctuation with one finger, but if you practice the manœuvre on patients with large amounts of ascites quite often you will be able to detect small quantities of fluid by rectal examination, and very occasionally such detection will be an important point in the diagnosis of an obscure case.

Differential Diagnosis.

The ascites may be part of a general anasarca, and there will be other clinical features to assist you, or it may be a localised abdominal finding, in which case the diagnosis may be more difficult. In the female the differential diagnosis between ascites and a large ovarian tumour is sometimes a problem. But a large ovarian tumour arises from the pelvis and will distend the abdomen below the umbilicus. The maximum girth will be at a lower level than is the case in pure ascites. A large ovarian tumour does not necessarily give

regular enlargement of the abdomen. It will not give the bulging in the flank, and it should be felt on rectal or vaginal examination. The difference really is this, that ascites or fluid collects with bulging in the flank, but only later does it collect suprapubically, whereas in the case of an ovarian mass it will be found that the distension begins suprapubically.

Treatment.

The patients usually are best in bed. If they have congestive failure or a tuberculous condition they will have to be in bed. But ascites can be a very persistent and chronic malady and its existence may be quite compatible with the patient being up and about. As far as diet is concerned, there should be some restriction in fluid intake, but it is more important that the diet should at least be salt-poor or, if possible, salt-free. A salt-poor diet is relatively easy to obtain ; a salt-free diet is extremely difficult and calls for quite elaborate processes and the services of a very competent dietitian.

Diuretics are of value in chronic cases. Mersalyl, 1 or 2 cc., is extremely useful. If there is a good deal of ascites with tense abdominal distension quite often you will find that the urine in such cases contains albumen, and we think that such albuminuria is due to the pressure on the renal vessels—relative renal anoxæmia. In such cases the drug is of little help. Its value, however, can be enhanced by paracentesis of the abdomen. Paracentesis is the most direct attack which you can make on ascites, but it is often a disappointing procedure. You have a patient whose abdomen is as " tight as a drum " and you anticipate that paracentesis will give you pints and pints of fluid. Instead, after draining rapidly for a short while the flow suddenly decreases and finally stops.

Strict asepsis is essential. You have a choice of sites, namely, in one or other iliac fossa or in the mid-line, but whichever site you choose do make sure that the patient's bladder is empty before you start. A little local anæsthetic is given, and a sharp trocar and cannula is pushed into the peritoneal cavity. The cannula is then connected by a length of sterilised rubber tubing to a Winchester containing antiseptic and the operation is completed. At first you are likely to get a gratifying response, but soon after, the omentum tracks across and seals off the end of your trocar, so that the fluid ceases to run. But you can repeat the process in other sites.

When the fluid is reduced, careful abdominal palpation will often reveal lumps, masses, or enlargement of the liver, which were not apparent before. Another piece of information for prognosis which may be of value is afforded by the rapidity with which the fluid re-collects. Rapid re-collection of the fluid suggests continued peritoneal irritation.

Special Conditions.

Now let us give a little detailed consideration to the occurrence of ascites in chronic hepatic disease and in malignant disease. In " chronic hepatic disease "—cirrhosis of the liver—probably all the three factors which I spoke about earlier are in operation. There is fibrosis of the liver which raises the portal pressure. More important is the reduction in the plasma proteins which always occurs in liver deficiency—you will find that when the plasma

albumen is reduced to 3 g. per cent. or a little lower, then ascites will occur. There is also evidence of increased permeability of the capillaries. You will remember that one of the clinical features in chronic hepatitis is the occurrence of " spider nævi " on the palms of the hands and scattered elsewhere on the body. This is due to dilatation of the capillaries, and it would appear to be just one step further from the occurrence of such nævi to the leakage of the fluid into the peritoneum or omentum from them. Thus all three factors may be working. It is desirable to influence, if one can, the plasma proteins. In America very encouraging results are claimed for the use of a high protein diet (150 g. of protein) with the addition of all the members of the vitamin B complex and the use of a crude liver extract, parenterally, with the addition of sulphur-containing amino-acids, such as 5 g. of methionine daily.

Where liver function is satisfactory—and it appears that the ascites is due to the increase of portal pressure, which may be shown by a history of hæmatemesis, enlargement of the spleen, or the presence of varicosities—attempts are being made to deal with the condition surgically. The procedures are very delicate and you will remember that Blalock spoke to you about them a year or two ago. They are formidable procedures and not for patients whose liver function is poor.

Finally, a few words about the treatment of malignant ascites. Here again perhaps I should have said " management " because I do not want to pretend that physicians have anything over the surgeon in the management of malignant disease. But so often one is faced with a patient with inoperable malignant disease whose chief symptom is ascites. His primary growth remains small, metastases are widespread, but not involving any vital structure, and therefore the patient remains well, apart from enormous ascites. These are the patients in whom, when some fluid has been removed, large masses are found in the abdomen, or in the liver, and rectally you feel what the Americans so picturesquely and accurately describe as a " frozen pelvis," the whole of the pouch of Douglas being solid with growth.

Paracentesis in these patients is most disappointing. The ascites itself may be almost gelatinous, for it is an exudate with a high protein content, as opposed to the transudate which you see in such a condition as congestive failure.

To begin with, these patients present us with a pure abdominal problem, but as the ascites increases they get a little œdema of their legs, and that may spread until finally the whole of the lower half of the body is grossly œdematous. This may be due to masses of growth pressing on and occluding the venous return from the lower half of the body. Occasionally it is due to the ascites itself impeding the venous return from the lower half, but whichever it is you can often improve these patients decidedly by getting them to remain sitting up throughout the 24 hours, in a cardiac bed, so that as much of their dropsy as possible falls to their legs. Then with strictly aseptic precautions you may incise the legs three or four times on the dorsum of each foot, just through the skin, the incision being not more than a quarter or half an inch long. This allows the œdema fluid to escape. Draining may occupy several days, the patients being kept sitting up. This drainage through the legs is not a curative treatment but it is a useful palliative measure in an otherwise uniformly depressing disease.

Some Lessons of the Exchange, 1948

By H. J. B. ATKINS, D.M., M.Ch., F.R.C.S.

(*Continued*)

INTESTINAL.

1. *Clinical.* A fascinating array of interesting intestinal cases was seen, for instance an adeno-carcinoma of the anus ! Perhaps, however, when the upper reaches become available for examination under an anæsthetic, this will be found to be a carcinoma of the rectum spreading downwards, in itself sufficiently rare to be of the greatest interest.

Much discussion took place on congenital polyposis of the colon, and Cuthbert Dukes' work is widely known and appreciated. Dr. Ravitch has done much work on these cases and he stressed the difficulties in diagnosing the extent of the lesion at laparotomy. Bleeding, shall we say, has taken place from the bowel and sigmoidoscopy reveals polyps, the family history is suggestive, but radiography does not demonstrate any lesions of the upper colon. At laparotomy neither by palpation nor by transillumination are any further polyps evident and yet they may be present throughout the colon, soft and so impalpable, small and so transmitting light. Two courses are possible, to open successively higher portions of the bowel and look inside and see, gauging the extent of the colectomy upon what is found ; or doing a routine colectomy when polyps are seen in the sigmoid colon. Dr. Ravitch has not yet made up his mind as to which is the wisest course. He also describes a syndrome where isolated polyps occur in the stomach, small intestine, and colon. This is not familial, although both stomach and colonic polypi are liable in this syndrome to malignant change.

One interesting case of megacolon was shown, a case which subsequently turned out to be complete reduplication of the colon with megacolon ! Spinal anæsthesia has not been found to be suitable treatment for cases of megacolon, and although some success has been reported from sympathectomy, the greatest fear is volvulus of the colon, and it is felt that if conservative measures are of no avail at least the localised forms should be treated by partial colectomy.

2. *Experimental.* As might be expected, much experimental work on intestinal surgery goes on in the Hunterian Laboratory. While I was there two fourth year students were conducting an interesting experiment. A loop of jejunum had been isolated and implanted subcutaneously with its free ends discharging through the skin. The gut had been reconstructed by end-to-end anastomosis, and it was proposed to allow the isolated subcutaneous jejunal loop to become vascularised by the subcutaneous tissue, as had been shown to occur previously by Dr. Longmire. When time had been allowed for this, the pedicle was going to be cut, thereby depriving the loop of its nerve supply. Subsequently the loop was to be reinserted into the intestinal canal and peristalsis of the denervated loop studied by direct vision and radiologically. In another animal the loop would be replaced but the wrong way round, to see whether reverse peristalsis would occur under such circumstances.

3. *Operations.* I watched Dr. Muller, the other Resident, do a closure of a colostomy. His operation was virtually to excise the fistulous segment and perform end-to-end anastomosis by the aseptic technique of Harvey Stone. The operation was beautifully performed and the post-operative convalescence took place, under an umbrella of penicillin and streptomycin, as usual without incident.

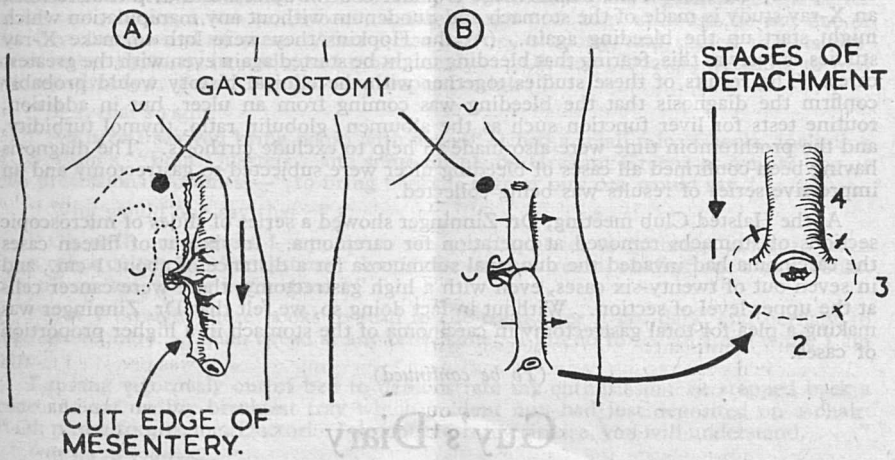
Dr. Ravitch performed his special operation of total colectomy for polyposis. This consists, as recently described (Surgery, 1948, Vol. 24, II, 170) in doing a submucous resection of the anus within the sphincter, then breaking out through the wall of the gut above this level and removing in the ordinary way the whole of the colon from the abdomen. The ileum is now threaded down through the anal musculature and sutured to the skin. Dr. Ravitch performs the operation for polyposis and for ulcerative colitis, where the friable nature of the anorectal mucosa makes the intra-anal dissection extremely difficult, and where the psychogenic nature of the disease prejudices against a good result. However, he has performed six such operations with good functioning anal ileostomies in four, although the immediate post-operative period is attended by much colic while the ileum is being distended to function as a rectum. In two cases the terminal ileum sloughed and one of these had the original abdominal ileostomy restored. This procedure obviously has great possibilities in cancer surgery and in the treatment of ulcerative colitis.

Perhaps the most interesting 'intestinal' operation was one which I saw at the

Veteraus' Hospital, where an artificial œsophagus was being modelled after the technique elaborated by Dr. Longmire and others in the Hunterian Laboratory.

A coloured boy had developed a corrosive stricture of the œsophagus and stomach through swallowing some material of unknown constitution and administered to him feloniously. The fact that his arms and face were burnt when he spat out the remains of the first mouthful indicates that the substance, whatever it was, was pretty potent! The immediate treatment was complicated by a tracheo-bronchial fistula and a mediastinal abscess which had to be drained, and, whereas at first a tube was passed down the œsophagus, this inadvertently came out and could not be replaced, so gastrostomy was performed.

When I saw him, 30 cm. of jejunum, 25 cm. from the ligament of Treitz, had been isolated and implanted subcutaneously as described above. One main jejunal artery and vein had been preserved as a pedicle, the length of the jejunum relying for its vascular supply on the distal arterial arcade (Fig. 5). The proximal end of the loop was brought out subcostally and the distal end in the left iliac fossa, an end-to-end anastomosis having been performed on the bowel remaining within the abdomen. The isolated loop had then been wrapped in two skin pedicle grafts above and below the issuing pedicle. Intermittent daily compression of the pedicle had begun six weeks after this and had been continued on each occasion until the exposed mucosa at either



(Fig. 5)

end looked blue. As the loop came to be nourished more and more by the skin pedicle and less and less by its mesenteric pedicle, this could be occluded for longer and longer periods without harm to the loop, and when it could be clamped thus for eight hours the mesenteric pedicle was to be cut and the middle of the loop grafted. The lower end would then be detached in stages and sutured to the gastrostomy opening. Finally the upper end was to be swung up and sutured to the œsophagus in the neck, the pedicle opened out and the jejunum 'snugged down' in an incision in the chest wall!

MISCELLANY.

1. *The Stomach and Duodenum.* The surgical treatment of peptic ulceration of the duodenum was an ever-recurring theme at surgical meetings and conferences. Some would recommend vagotomy as a routine, others abhorred it; some would treat hæmorrhage from a duodenal ulcer by vagotomy and gastrojejunostomy, others thought that in so doing surgery had reached a new "low." So the discussions swung back and forth in a fruitless endeavour to reach a conclusion without evidence. Dr. Trimble, who is editing a new edition of Lewis' Surgery, has written to many prominent American surgeons asking their views on vagotomy: Wangenstein will have none of it, Dragstedt now always does a gastrojejunostomy with vagotomy; he asked me what I thought about the matter from my discussions at the Hopkins and elsewhere, and this is what I told him.

In the treatment of duodenal ulcer high subtotal gastrectomy gives excellent results in nearly ninety per cent. of cases. This is not conjecture, but a fact which has now

been tested over twenty years. The effect of vagotomy is still unknown; it might be as good, it might even be better, it might be worse, only time will tell. Let us stop discussion until we have more facts to go upon. What then is the present position? We believe that vagotomy is indicated in gastro-jejunal ulcer. Why? Because the mortality of gastrectomy in this condition is sufficiently high for us to choose an operation which may not be quite as good, but which has a negligible mortality and, as a well-known member of the Guy's consulting staff is wont to remark, "the first object of surgery is to end up with a live patient." But there is another circumstance that increases the mortality from gastrectomy, namely, a scarred, adherent duodenum. To avoid difficulties here, "get out" operations such as Bancroft's submucous resection of the pyloric mucosa and the two-stage operation have been devised as "safe" alternatives. Might it not be that there is a place for vagotomy here too? As I see it the present position is roughly this: vagotomy is indicated in gastrojejunal ulceration, in ulceration with a scarred and "difficult" duodenum, and in every case in those institutions where the results of vagotomy are being studied scientifically for the purposes of final evaluation. In fact an eclectic attitude must be adopted until the state of affairs within the abdomen has been appraised.

At the University of Maryland Hospital 'down town' I discussed with the Residents their treatment of acute hæmorrhage from a gastric ulcer. First the diagnosis must be confirmed. As soon as the hæmorrhage is under control by rest and drip transfusions, an X-ray study is made of the stomach and duodenum without any manipulation which might start up the bleeding again. (At the Hopkins they were loth to make X-ray studies as early as this, fearing that bleeding might be started again even with the greatest care). The results of these studies together with the clinical history would probably confirm the diagnosis that the bleeding was coming from an ulcer, but in addition, routine tests for liver function such as the albumen : globulin ratio, thymol turbidity, and the prothrombin time were also made to help to exclude cirrhosis. The diagnosis having been confirmed all cases of bleeding ulcer were subjected to gastrectomy and an impressive series of results was being collected.

At the Halsted Club meeting, Dr. Zinninger showed a series of slides of microscopic sections of stomachs removed at operation for carcinoma. In six out of fifteen cases the carcinoma had invaded the duodenal submucosa for a distance of about 1 cm., and in seven out of twenty-six cases, even with a high gastrectomy, there were cancer cells at the upper level of section. Without in fact doing so, we felt that Dr. Zinninger was making a plea for total gastrectomy in carcinoma of the stomach in a higher proportion of cases.

(*To be continued*)

Guy's Diary

FEBRUARY

ACADEMIC

Jan. Exhibition. Surgical Dept. "Goitre."

31st. 1.00. Dr. Rink. Clinical Lecture. "Complications of Anæsthesia."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. Vertue. Dept. of Child Health. Postgraduate Lecture. "Pleasure at the Helm: The Treatment of the Normal Infant."

Feb. Exhibition. Surgical Dept. "Twenty Questions."

1st. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.
1.00. Dr. C. G. Baker. Clinical Lecture. "Blood Pressure."

3rd. 1.00. Mr. Grant Massie. Clinical Lecture. "Injuries of the Wrist."
4.30. X-ray Meeting. Gordon Museum.

4th. 1.00. Dr. Hampson. Clinical Lecture.
2.15. Medical Dept. Combined Round. Preclinical Classroom.

7th. Commencement M.R.C.P. Course.
1.00. Mr. Law. Clinical Lecture. "Errors of Refraction."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. P. R. Evans. Dept. of Child Health. Postgraduate Lecture. "Dosage of Drugs for Children."

8th. 5.00. Dr. Bishop. Endocrine Lecture. Preclinical Classroom.

10th. 1.00. Mr. Lloyd. Clinical Lecture. "The Course and Prognosis of Syphilis."
4.30. X-ray Meeting. Gordon Museum.

11th. 1.00. Dr. Hardwick. Clinical Lecture.
2.15. Medical Dept. Combined Round. Preclinical Classroom.

12th. 10.00. Mr. Naunton-Morgan, St. Bartholomew's Hospital. Surgical Dept. Round. Clinical Theatre.

14th. 1.00. Mr. Atkins. Clinical Lecture. "Ulceration of the Skin."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. J. K. Martin. Dept. of Child Health. Postgraduate Lecture. "Constipation."

SPORT

Feb.

5th. Rugby XV. *v.* Coventry. (H.O.P.).
Hockey 1st XI. *v.* Lloyd's Bank. (Away).

12th. Rugby XV. *v.* Swansea. (Swansea).
Hockey 1st XI. *v.* Inland Revenue. (H.O.P.).

To Budapest—The Second Journey

By DAVID STAFFORD-CLARK.

(concluded)

The section of Neurology and Psychiatry opened with a Presidential address followed by the presentation of papers on the morning of Monday, September 6th. I had discovered from my programme that I was due to read my paper on the opening morning: all papers were to take approximately twenty minutes and to be followed by five minutes for discussion. Accordingly I spent a little time before retiring to bed on the Sunday night, ensuring that the paper would run as nearly as possible exactly to time. I was awakened the next morning by a knock on my door followed immediately by the entry of four beaming visitors. The first was my host, the Neurological Registrar, followed by another registrar bearing a massive visitors' book bound in scarlet leather and lettered in gold; after them came a pale dark young man and a pale blonde young woman. She, it appeared, was the H.P. to the Unit: he a clinical assistant, consumed by ambitions, tormented by well-founded suspicions that his place in the Unit was far from secure, and above all anxious to improve his status by deft demonstrations of his undoubted linguistic abilities in conversation with me, whom he assumed quite mistakenly to be a man of some influence with his ultimate chief. Unfortunately his eagerness got the better of his tact; never, I was to discover, a strong point with him, although he was one of the best intentioned of men. After I had sat up, blinking, and signed the visitors' book in my pyjamas, he addressed me suddenly: "Oh dear, Doctor, we think to find you up already! Soon you read your paper I think?"

"Yes, that's right."

"Ah here I see you bring books with you—" (I had a small pile of books, including T. S. Eliot's "Four Quartets" and some novels by Graham Greene as well as one or two professional volumes)—"to bring books is a great pity one would say."

"Why would one say that?"

"Oh well, one travels I suppose to see new countries to exchange ideas, to learn from other cultures, other systems: but if one sits in a room, reading one's own books, it is all missed, where is the good?"

"But I brought these books to read in the train after it got dark, and perhaps to read in bed here. I shan't read at any other time: I intend to see all I can while I am here."

I sprang vigorously out of bed to demonstrate my enthusiasm: he stepped back a pace and sat on my breakfast tray which a silent nun had just deposited on a chair. "Oh please forgive me, Doctor. I do not mean to criticise, you will understand. . . ."

"Why of course—."

"Now we all go: soon we come back to escort you to the Neurologic Clinic." We parted, with assurances of goodwill; but not for long. While I was putting on my shoes he returned.

"Good: you are ready. We go at once. Now tell me about your lecture; it will not be much I suppose?"

"Well suppose you tell me what you think when you've heard it."

"No—No. . . Forgive: I meant it will not be of great endurance. You see I have to read the summary you sent last month, for translation. But the summary is very short—you would say I think laconic—concise—tells very little. We are all impatient with interest now."

"You're very kind. . . ."

The summary I had sent had been modelled on accepted lines for English journals: less than 150 words, it indicated no more than the scope and outline of the paper, with essential conclusions. When I saw how most of my colleagues had spread themselves in the official summaries supplied in translation before each paper, I understood my pale companion's earlier perplexity on receiving mine. By comparison it was indeed laconic. A comparable exuberance characterised the papers themselves: my immediate predecessor, whose contribution followed directly upon the opening address of the President of the section and bore the comprehensive title of "the Psychoses and Psychoneuroses," exceeded his allotted twenty minutes by another fifty-five. Throughout the entire Grande Semaine Medicale—at least in the Neuropsychiatric section—barely

half a dozen contributors proved able to contain themselves within the prescribed time limits. As is to be expected in all such gatherings, the papers varied considerably in interest and quality: some were purely professional, some heavily flavoured with political bias, while some soared effortlessly into fantasy or became bogged down in metaphysics. Examples of the first group, chosen out of many, were papers on histological examinations of brains of mentally ill patients originating from one family, by Professor Santha, of Debrecen University; the role of personality and the examination of intellect in psychaitry, by Professor Boszornieny; and the problem of neurotropic virus infections in Rumania, by Dr. Draganesco. Two titles only need be quoted from the programme to exemplify the other two groups: "Psychic backgrounds of laziness and its importance as a mass disease," and "Muses of the Fight for Freedom."

I found it interesting that in the course of a number of carefully prepared papers on virus meningitis and encephalitis, and allied chronic inflammatory processes in the brain and meninges, not one case of Torulosis was mentioned. Subsequent discussion revealed only one reported case in Hungary, but this of course was based entirely on personal recollections and not upon a search through the literature.

The watchful intensity of the Clinical Assistant proved something of a strain when undiluted, and I readily accepted diversion in the company of one of the ladies who had acquired from the committee the status of interpreter and guide for foreign visitors to the Congress. My companion was a charming widow whose hand was being desperately sought by one of the doctors at the hospital, and also by a member of the organising committee. At about noon on the Tuesday after an exhausting session at the Clinic, we were sitting having coffee in a square overlooking the Danube, called Molotov Ter., when she suddenly remarked to me:

"This morning my friend Monsieur X received anonymous letter about me."

"Did he? How very unpleasant for you both."

"It was about you too."

"What?—No—Not really—What did it say?"

"It say Dr. Y at the hospital think it best to give me up to you, to end their rivalry or something stupid like that, and that now he is finished: the visitor from England has finished him."

"Who is finished? Dr. Y.?"

"No, Mr. X. Well, both of them I suppose."

"Why that's preposterous—No—please don't think me ungallant—but surely he didn't take it seriously?"

She laughed—a trifle ruefully it seemed to me.

"Well—he was quite upset. He wondered what it was all about."

So indeed did I. I had been in Budapest scarcely more than forty-eight hours at the time. I was to have a further illustration of the City's powers as a culture medium for exotic rumour before another twenty-four hours had passed. That evening I was invited to join a party of young doctors from the hospital, with their wives and my interpreter, in a steamer trip up the Danube. Before the war it was possible to travel the entire length of the river, from its origin in the Black Forest, through Germany, Austria, Czechoslovakia, Hungary, Yugoslavia, Bulgaria and Rumania to the Black Sea, as a pleasure cruise. Now although woefully limited in extent to the particular country in which one happens to be, steamer trips have again exerted their appeal in most of the countries through which it flows, and in none more than Hungary whose capital has long borne the title of the Queen of the Danube.

It was an enchanting experience. We left the pier at about 7.30 p.m. and steamed gently upstream through the darkening evening, past St. Margaret Island, joined by a newly repaired bridge to each bank, once itself the most famous beauty spot and pleasure garden of the city, now sacked and ravaged by the Germans in their last desperate struggle to hold the capital against the triumphant Russian advance. By the time they were finally defeated they had destroyed every one of the seven splendid bridges between Buda and Pest which were the pride of the city and the river. Now three have been rebuilt and a new one, the Louis Kossuth Bridge, called after the 1848 revolutionary leader and head of the first Hungarian Republic, has been added. We remained on deck and were served with supper under an awning, by the light of tiny lanterns, as the steamer left these bridges and the island behind, and gained the wide dark waters to the north of the city. Then we turned slowly and headed back, seeing

all the lights on both banks ahead, and on the top of St. Gellért Mount on the western bank, the floodlit Liberation Monument. This impressive statue has as its subject a woman facing eastward across the Danube and holding aloft a wreath in tribute to the soldiers of the Red Army killed in the battle for the city. Not all Budapest's war memorials are as beautiful or expressive. Molotov Ter., where again I met my interpreter the next morning, has in its centre a marble plinth surmounted by a metallic model of a Russian aeroplane, remarkably like a Mosquito. This elevation of a piece of destructive machinery to symbolic eminence is not without irony under the circumstances: I was reminded of the Children of Israel and their Golden Calf.

It was evident that my friend had something on her mind. She broached it gently:

"I don't know whether I should tell you this. . . ."

I said nothing, but smiled encouragingly. When people begin in this way they are usually pretty determined to tell you anyway. She was no exception.

"Do you know Dr. A.?" she asked. Dr. A. was an eminent British neurologist, and as it happened, the only other English visitor in the section of Neurology and Psychiatry.

"Yes. I've met him."

"But do you know him well?"

"No, I wouldn't say that."

"Well, could he wish to harm you for any reason?"

"I shouldn't think so for a moment. Why?"

"Well—this is very difficult," she sighed—"but I think I must tell you. Yesterday a hostess here ask me are you and Dr. A. friends? Should she ask you out to same parties together? I say I don't know, I will ask you. She say 'No,' it is better if she make discrete enquiries herself—."

"Yes. Go on."

"Last night before we go on steamer she tell me she learn that Dr. A. is very angry you are here. He say 'Who ask Dr. Stafford-Clark? When I last meet him he is in trouble over gambling debts in Paris. I do not want to meet him again here.'" She paused and looked at me anxiously; "I tell her I cannot believe it. She tell me I mustn't say anything to you; but you have a right to know what is said. Could it be that Dr. A. is jealous? Or is it true?" Her tone was an engaging blend of wistfulness and hope. Across the Danube, with a deafening crash, one more condemned building crumbled into dust as the dynamiters continued their enormous task of clearing the wrecked third of the city. For a moment my sense of proportion wavered; almost it seemed as though the honour of English medicine was at stake. I said:

"I'm quite sure Dr. A. never said anything like that at all. Someone's been making it up. As far as I know A. and I have never been in Paris at the same time; I've certainly never met him there, nor have I ever got into debt or gambled there in my life. Furthermore its inconceivable that he should be jealous of me because he's at the top of the profession and I—well I'm just lucky to be here at all."

She accepted this without a trace of hesitation.

"You are probably right. In these days there are so many things we dare not talk about that for some people a private scandal is like a breath of fresh air—."

"I think I see what you mean."

"Yes perhaps you do: you are a doctor. It is a symptom of our sickness when we are so ready to be suspicious."

It was a symptom that might easily prove infectious. I spent that afternoon visiting some of the famous thermal and mineral baths of Budapest. These are fed by no less than 117 springs and have been renowned for their curative powers for over 1,000 years; it was fascinating to see the famous bathing pool at St. Gellert's spa with its artificial waves, and to watch the rheumatic sufferers in St. Luke's thermal establishment lying like hippopotami on the banks of the Nile, stark naked, while lusty attendants slapped bucketfuls of radioactive mud over their legs and hips. But all the time a part of my mind was busy with the fantastic conversation of the morning, and with futile and repetitive speculations as to its basis. I saw Dr. A. briefly that evening, at a cocktail party at the British Embassy: we nodded and smiled. The next day we were both invited to lunch at the Consulate: he was absolutely charming to me. One day perhaps I shall tell him about the legend which so oddly linked our names in Budapest; or perhaps he may see a copy of this article.

The Grande Semaine Medicale reached its climax with an open-air banquet given by the Minister of Health, and the presentation of delegates to the President of Hungary. Meanwhile the pleasant circle of friends I had made at the hospital excelled in more personal hospitality. I was invited to the Neurological Round of Professor Lehoczky, the chief of the department, and, on my last night in Hungary, taken for dinner to a restaurant on the top of one of the highest hills behind Buda, by his registrar and some other colleagues.

This was my last and most picturesque memory of Hungary. I left Budapest on the night train for Prague on Sunday, September 12th: I still had the Czech notes tucked inside one of my books, and it was with some relief that I was able to spend them on some breakfast the next morning. I was met at the station by my Czech friend, and he devoted his entire day to showing me over his hospital and around Prague. Unlike Budapest, Prague has escaped large scale damage, although several historic buildings were deliberately wrecked by the retreating Nazis. It is a city of medieval castles, of baroque churches, of exquisite bridges and statues, and contains the famous Clock of the Apostles which tells the year and indicates which astral bodies are in the ascendant, as well as supplying the more usual information.

The following morning I began my final journey home, which I was to complete with no further excitement beyond the collapse, in clouds of steam, of the engine of the Orient Express on the lonely stretch of single track leading to the frontier post at Cheb. This delayed us nearly two hours but we were able to make up the time by cutting out most of the scheduled wait in Nuremburg and Cologne, which may well have been originally inserted in the timetable to cover such contingencies. European locomotives are notoriously overdue for replacements and breakdowns are by no means uncommon.

Back in England I tried to answer questions honestly, fairly, and as objectively as I could. Did I have any difficulty in getting through the Iron Curtain? None. Was Hungary overrun with Russian soldiers? I didn't see one. Did I see any Russians at all? Yes: in the Russian Pavilion of the Czech Autumn Fair. What were they like? Friendly, as might be expected under the circumstances. . . .

Had I any particularly vivid memories? Yes, I had several. One was my first long conversation with Mon Pére: another, towards the end of that last evening in Budapest, on the terrace of the mountain restaurant with my friends from Szent Istvan. Far below us the whole curve of the river and the city embracing it glowed with light. A tiny steamer, decked out with lanterns, crept slowly northward past St. Margaret Island.

"You will remember this," they said.

"I will."

"Will you come back again?"

"I hope so."

It was true—and yet I could not say it without misgiving. Now, in retrospect, that misgiving is stronger still. Not because Mon Pére has died, but because Cardinal Mindszenty and Bishop Ordas have been arrested, because teachers in Hungarian Universities who were unwilling to join the Communist Party have been removed from their jobs, because the grip of political materialism is tightening steadily upon a beautiful country and a charming and friendly people, replacing feudal dictatorship and Nazi domination with the threat of yet another tyranny. Some of those who were kindest to me would not see it in this way. Indeed, as sincere Communists they might be angered or outraged by what I have written; and if they were associated with these opinions by those in authority over them they would certainly have cause to be appalled; just as I am appalled by the ultimate prospect of the fate which they, perhaps unwittingly, are helping to bring upon their country.

* * *

These then were the two journeys; south-eastward to Lisbon, south-westward to Budapest, and this tale of them contains nothing but fragments of the challenging mass of experience which any traveller must bring home with him, whether he seeks it or not, whether he travels for pleasure or for sterner reasons. Such experiences, acquired perhaps in days or weeks, may in retrospect take on the significance of whole chapters of a lifetime, and in gradual distillation may, as they recede, help to colour all that follows them.

Travellers' tales can never be purely descriptive, nor purely objective. The task as I see it is to recapture and reflect something of the spirit of the journeys, something of the passion of the traveller, something of the adventure which lies at the heart of any expedition. This has been my endeavour: this and nothing more.

Correspondence

Teaching of Chemistry at Guy's

SIR,—One of the most important principles on which emphasis must be laid throughout a course of chemistry is the classification and order of the chemical elements.

With the usual equipment found in most chemistry departments it is often difficult to keep this important aspect of the subject continually before the student. This difficulty has been efficiently solved in our Chemistry Department, by the carrying out of a suggestion made by Dr. W. L. G. Gent. Dr. Gent has devised a diagram for instructional purposes, embracing the essential results of modern investigation on atomic weights and atomic numbers. He also suggested that this should be painted on a wall of the chemistry lecture theatre, so that the diagram is immediately available at all times. The painting, in contrasting colours which have significance, has been efficiently carried out by the Artist-Painter of the Works Department.

I do not know any other chemistry department which has adopted this method of emphasising always the importance of the classification of the elements in a knowledge of chemistry.

I should like to thank Dr. Gent, the Artist-Painter, and the Works Department, for the manner in which they have carried out the work. It is most creditable.

Yours, etc.,

Guy's Hospital, S.E.1. C. S. GIBSON.

The St. Christopher Fund

SIR,—At a Meeting of the Governors of this Hospital held on 11th January, 1949, I reported that the St. Christopher Fund of the Bank of England, a fund organised by the staff of the Bank, was to continue at the wish of its members to provide support for Guy's Hospital. This support is to be given in the following ways :—

(*a*) The sum of £500 to be paid to the Hospital each year and up to this sum may be used to help members of the St. Christopher Fund who receive treatment in the private wards of the Hospital. Any part of this sum of £500 not used in any one year in this way will be credited to the Samaritan Fund of the Hospital.

(*b*) The balance of the subscriptions up to a maximum of £500 to be allocated to the Governors of the Hospital towards the upkeep of the rest-home and holiday-centre, "The Thatchings," Bognor Regis. The remainder of the subscriptions, if any, will be paid to the Hospital's General Endowment Fund for the provision of extra amenities for the patients and staff of the Hospital.

It was felt that this was such an outstanding offer of continued support that it would be of interest to all connected with Guy's.

Yours faithfully,

B. L. READ,

Guy's Hospital, S.E.1. *Clerk to the Governors.*

Obituary

EDWARD WILLIAMSON.

MANY Guy's men will learn with regret of the passing of Mr. E. Williamson, for many years Chief Pharmacist to the Hospital, who died after a long illness on Sunday, January 16th, 1949.

Affectionately known as "Father" Williamson by his staff, he will be remembered by many for his unassuming manner and unfailing willingness to help.

He joined the Dispensary staff under Mr. Finnemore and, on the latter's departure for Australia, was appointed Chief Pharmacist. He retired in 1933 but maintained a close association with the Hospital until the end.

Mr. Williamson was one of the old school of pharmacist and hospital servants; his passing severs yet another link with the past.

J.M.

Sport

BOXING

Tournament—Tuesday, 22nd February, 1949, Guy's Hospital B.C. v. St. Mary's Hospital B.C. and other special contests, at Seymour Hall, W.1. Tickets: 12/6, 10/-, 7/6, 5/- and 2/6, from the Counting House, Guy's Hospital (Hop 3334), and G. A. R. Winston, Wills Library (Hop 1014).

HOCKEY CLUB—ANNUAL DINNER

Thirty-six members attended a most enjoyable and successful annual dinner of the Hockey Club, held in the "Lower Spit" on Friday, January 21st. The President, Mr. A. D. Marston, was in the Chair. The Club's unbeaten record for the season was celebrated in appropriate fashion.

RUGBY

GUY'S *v.* LONDON IRISH

at H.O.P. Won 6—0.
27th November, 1948.

GUY'S *v.* COVENTRY

Away. Lost 3—11.
4th December, 1948.

GUY'S *v.* OLD CRANLEIGHANS

at H.O.P. Won 28—6.
11th December, 1948.

Superior in every department of the game, the Hospital had no difficulty in defeating the Old Cranleighans.

Three outstanding figures in the Guy's side were Brunow, Gray and D. Le Clus.

Brunow opened the scoring with a brilliant run round the blind side of the scrum to score on his own. Couchman then replied for the Old Boys' side with a well kicked penalty.

Two more tries by Heber and Gray, with D. Le Clus adding the goal points, brought the score to 15—3 at the interval.

Gray handed off his opposing wing, ran through and cross-kicked to Keeling who scored the fourth try, which again was converted by D. Le Clus.

Once more Brunow broke through, giving the ball to Gray who touched down behind the posts to give Le Clus his fifth conversion of the game.

A quick interception by Gibson gave the Old Cranleighans their remaining three points.

D. Le Clus finished his polished performance by joining the threequarters breaking through and sending Malyon over for a try.

GUY'S *v.* MOSELEY

at H.O.P. Lost 3—6.
18th December, 1948.

The standard of play was very poor on both sides in this match. The Guy's forwards gave one of their worst displays of the season, and the backs were not much better.

Within the first ten minutes, Gray beat his man on the wing, cross-kicked into the centre for Malyon to gather the ball and send Knipe over for a try. D. Le Clus' kick was wide of the post. Immediately after this Lewis replied with a penalty for Moseley.

With the Hospital play slowly deteriorating, Moseley began to get the upper hand and a passing move in the Guy's "25" finished with the Moseley right-centre, Harrison, scoring a try.

The second half was even more dull than the first. Of the backs, Gray was the only one who seemed to penetrate at all in attack and still have the energy to defend. Gwyn Davies of the forwards was the only one jumping in line-outs and generally working hard in the loose.

GUY'S *v.* O.M.T's.

Away. Lost 9—16.
1st January, 1949.

GUY'S *v.* WASPS

Away. Lost 3—6.
8th January, 1949.

GUY'S *v.* OLD ALLEYNIANS

at H.O.P. Won 6—3.
15th January, 1949.

GUY'S *v.* METROPOLITAN POLICE

at H.O.P. Won 9—0.
Saturday, 22nd January, 1949.

Conditions were ideal for the game against the Police. Guy's were weakened by the loss of Gray, J. F. Le Clus and Rademan through injuries.

The visitors' pack was soon getting more of the ball in the set scrums and line outs. Their backs, however, made little headway against keen tackling. After 15 minutes, from a loose maul 35 yards from the opponents' line, Davies and Hobbs dribbled the ball over, for Davies to touch down near the corner.

Just before half-time, Eckstein took the ball from a line-out, well inside his own half, ran strongly, passed outside to Keeling, took the return pass, and went over for an excellent try.

The second half saw the Guy's forwards very much on the ascendency and but for some poor handling by the backs two more tries would have been added. Finally, after a series of attacks, D. Le Clus made an opening in the centre, and passed outside to Burch who went over, far out.

Le Clus was unlucky with the conversion for the third time.

Davies was by far the best forward on the field—always up with the ball. Eckstein at wing forward was also prominent in a hard working pack. Of the backs, Brunow was outstanding, putting his side into attacking positions, or relieving pressure, with some fine kicking, and finding the gaps between the opposition backs.

It was refreshing to see so few penalties, only two in all.

* * * * * *

Aids to Anæsthesia. By VICTOR GOLDMAN. 2nd Edn. Bailliere, Tindall & Cox. *Price 7s. 6d.*

THIS very useful small book contains all the practical information that might be required by the newly qualified house-surgeon, who has to administer anæsthetics, and many facts of use to the specialist anæsthetist. The chapter on the "anatomy of anæsthesia" might well be left out, since the information it contains is so extremely elementary. The remainder of the book is excellent, and can be well recommended to anyone interested in anæsthesia.

D.M.C.

Correction.—The author of "The Modern Management of Gastric and Duodenal Ulcer," reviewed in the last issue of the *Gazette*, was Coxon Deller, and not Coxon Duller as was inadvertantly printed.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

Applications are invited for the posts of Junior Resident Clinical Pathologists (B.2), two vacancies, one on March 12th and the other on April 1st, 1949. Salary at the rate of £350 per annum with board residence. Applications should be lodged with the Superintendent not later than February 28th, 1949.

Applications are invited for the appointment of Assistant Physician to the Dermatological Department of Guy's Hospital (part-time), with attendance on two sessions per week with remuneration at the rate of £200 per annum per session, subject to revision when the new Ministry of Health scales of salaries are published. The appointment is of Consultant status, and applicants are required to hold a higher qualification. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 28th February, 1949. In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of members of the Board or Advisory Appointments Committee will lead to disqualification.

Applications are invited for the appointment of Assistant Physician to the Department of Psychological Medicine of Guy's Hospital (part-time), with attendance on not less than three sessions per week for adults and children, with remuneration at the rate of £200 per annum per session, subject to revision when the new Ministry of Health scales of salaries are published. The appointment is of Consultant status, and applicants are required to hold higher qualifications in their specialty. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 28th February, 1949. In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of members of the Board or Advisory Appointments Committee will lead to disqualification.

Applications are invited for the post of Resident Obstetrician for the period March 1st to May 31st, 1949. The appointment is restricted to men who have been qualified for at least one year. Salary to be at the rate of £350 per annum with board, lodging and laundry.

Applications should be lodged with the Superintendent not later than Thursday, February 10th.

Applications are invited for the appointment of Half-time Demonstrator in Special Anatomy and Histology to commence duties on 2nd March, 1949. Salary £550 × £50 to £750 per annum plus superannuation and family allowance.

Forms of application are obtainable from the Dean, Guy's Hospital Dental School, London, S.E.1, to whom applications should be sent not later than 11th February, 1949.

GUY'S HOSPITAL DENTAL SCHOOL

The following postgraduate courses will be held :—

Orthodontics and Children's Dentistry—a fortnight's course, commencing 14th March, 1949. Fee 20 guineas.

Dental Radiology—Three Saturday morning sessions, commencing at 10 a.m. on the following days, 2nd, 9th and 16th April, 1949. Fee 3 guineas.

Further details and forms of application may be obtained from The Dean, Guy's Hospital Dental School, London, S.E.1.

CLUBS' UNION COUNCIL

In accordance with the terms of the present Constitution, notice is hereby given that a Special Meeting of the Clubs' Union Council is to be held on Friday, 11th February, 1949, at which the following proposals involving alterations to the rules are to be considered :—

(i) Rule 24. To read :—

"No alteration of, or addition to, these Rules shall be valid unless it be confirmed at a subsequent meeting of the Council by a majority consisting of *not less than two-thirds of the members present and voting*. Of such proposed alteration or addition, the Secretary, at least fourteen days before the meeting of the Council at which it is to be confirmed, shall give notice in writing to the Secretary of each of the Constituent Institutions, and shall post a notice in the rooms of the Students' Club, and shall cause a notice to be inserted in the Guy's Hospital Gazette.

(ii) That membership of the Clubs' Union be compulsory for all students of the Medical School.

(iii) That the annual subscription, as from 1st October, 1948, be raised from the present figure of £4 4*s*. 0*d*. to £5 5*s*. 0*d*. per member.

G. D. CHANNELL,
Hon. Secretary.

PAPERS BY GUY'S MEN

Allsopp, C. B. The action of mustard gas on living cells *in Vitro*. *Cancer Res.*, 1948, **8**, 145.

——. The effect of mustard gas on the Skin of Mice. *Cancer Res.*, 1948, **8**, 177.

Batchelor, J. S. (1) Osteochrondral Fracture of the Patella; (2) Actinomycosis Simulating Osteitis of the Pelvis. *Proc. Roy. Soc. Med.*, 1948, **41**, 853.

Batchelor, J. S., and Cohen, Sol. M. Osteopathy: a visit to the London College. *Lancet*, 1948, ii, 1021.

Clarkson, P. The use of skin tension and abrasion in the relief of facial pock marks. *Med. Pr.*, 1949, **221**, 17.

Eckhoff, N. L. Rodent Ulcers. *Clin. J.*, 1949, **78**, 9.

Evans, P. R. Antecedents of Infantile Cerebral Palsy. *Arch. dis. Child.*, 1948, **23**, 213.

Macintosh, R. R. An aid to Oral Intubation. *Brit. Med. J.*, 1949, i, 28.

Moffatt, P. McG. Exfoliation of the Lens capsule in each eye. *Proc. Roy. Soc. Med.*, 1948, **41**, 750.

Punch, A. L. Tuberculosis and the Law. *Brompton Hosp. Rep.*, 1947, **16**, 182.

Shaw, A. Batty, and another. Paratyphoid "B" Fever. An epidemic remarkable for its mildness. *J. Roy. Army Med. Corps.*, 1948, **41**, 189.

CHANGES OF ADDRESS

Bryant, Peter, M.B., B.S., Residents' Quarters Postgraduate Medical School of London, Ducane Road, Hammersmith, W.12.

Attale, Jeffery E. E., L.D.S., R.C.S., Longdene Lodge, Haslemere, Surrey. (Tel. : 17.)

Whitlock, R. I. H., B.D.S., L.D.S., Maxillo-Facial Unit, Queen Victoria Hospital, E. Grinstead, Sussex.

BIRTH

SYKES.—On January 19th, in the Howard Nursing Home, Maidstone, to Moira (née Tomlin), wife of F/Lt. Michael J. L. Sykes—a son (Roger James).

DEATH

WILLIAMSON.—On January 16th, 1949, Edward Williamson, formerly Chief Pharmacist, a valued servant of Guy's, aged 79 years.—29, Merton Hall Gardens, S.W.20.

Eds. { H.A.R.
R. G.

Guy's Hospital Etchings

ETCHINGS 5/- EACH

The Entrance Gates
The Main Entrance
The Quadrangle
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(Post 6d. extra)

The Hospital from the Park } **3s. 6d.**
The Front Gates - - } **each**
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GUY'S HOSPITAL GAZETTE

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PASSIM

TO be 'shaken rigid' is a soldier's colloquialism which no more refers to electro-convulsive therapy than does his wife's 'I was frightened stiff.' Both are observations by the lay public on the effects of an emotion on function. Tension, with increased muscular tone quite unrelated to the demands of posture or activity, with consequent fatigue and pain are no uncommon results of being afraid. Loss of appetite, loss of weight, loss of sleep, do we but bother to consider the matter, are frequent manifestations of fear, and one and all are undesirable, one and all a handicap to the process of recovery in a patient—that is, a person either physically or mentally ill already.

John Ryle, in his Maudsley Lecture a year ago, on Nosophobia, quoted first Sir Philip Sidney,

"Fear is more pain than is the pain it fears,"

and went on, while considering the doctor as an aetiological factor in the genesis of the condition, to state that, 'the teacher at the bedside who drifts too easily into pathological discussion is doubly at fault, for he may at once puzzle or disturb his patient and set a bad example to his class.' Later we find, 'Cancer phobia without cancer is, however, far common than cancer phobia with cancer' Ryle is a very careful and accurate observer, as anyone who has had the privilege to be his ward clerk will testify. This latter remark, taken in conjunction with the quotation from Sir Philip Sidney, may give some food for thought, and some indication of the possible harm which may come from the casual word let fall on a teaching round or at an out-patient clinic by the careless teacher. That is considering the matter from the humanitarian view point rather than the organic, with its more evident manifestations.

Recently a surgeon of this hospital went to pay a final visit to a patient about to be discharged after having undergone a radical mastectomy for carcinoma mammæ.

"Tell me doctor—and honestly, please—can I expect to be one of the thirty per cent. or one of the seventy per cent.?"

"You must explain. What do you mean?" he said.

"Well you told the young doctors that only thirty per cent. survived ten years—of people like me in group two—according to Gordon Taylor. I wondered if you could tell me whether I should be one of the seventy per cent. who died, or possibly one of the thirty."

Attention has been drawn to this matter again and again, in the pages of this journal. Harold Chapple in 1944, discussing the outcome of investigations in places elaborated for the purpose was referring to certain expensive clinics, but might well have been alluding to something nearer home. He commented on the patients, that 'they had very little the matter with them when they entered the imposing portals, but a good deal when they came out.'

To set out with a suspicion of disease and to finish with a dread of death, is a poor passage, a bad trip. To come into Guy's with gastritis, and to go out convinced of the presence of a carcinoma of the stomach is not a fair exchange, and is worse than robbery.

Did we but bother to consider the matter of casual words by careless teachers, then we would put our house in order. And we *must* bother.

GUY'S Dental Men are reminded that the last day for sending in their application forms for the Annual Dinner of the Dental Society, to be held at the Park Lane Hotel on Saturday, 5th March, is Friday, 18th February. Also we have been asked to draw attention to the Boxing Tournament (including Guy's v. St. Mary's) to be held at the Seymour Hall on 22nd February. As the proceeds are to be devoted to the Pavy Gymnasium Fund, it is thought that this tournament should be well supported by the students of the Hospital.

The Film in Medicine

By RONALD MAC KEITH, D.M., M.R.C.P.

THE HISTORY OF THE MEDICAL FILM

THE ingenious method employed by Muybridge in 1872, to analyse the gait of a trotting horse by means of a series of photographs taken with a row of cameras, was quickly adapted to medical use. A textbook of diseases of childhood published in 1895 contains serial photographs of children walking and running ("Copyright 1887 by Edward Muybridge"), together with analyses of the limb movements based on them.

In the same way, medical men were quick to use the cinematograph. In 1897, two years after the first public cinema show in Paris, Braun filmed the mammalian heart and Schuster made records of abnormal gaits. (Fifty-two years later, there is still no adequate set of film records of various typical gaits !).

In 1898 the French surgeon, Doyen, had a film made of an operation in order to study the movements of his hands. The film ended its career as a side-show in a circus and is lost; which is a pity as the surgeon is said to have been in "faultless evening dress." In 1899 Doyen, in an article in Révue Critique de Médicine et Chirurgie, spoke of the double usefulness of the film—to enlighten himself and his students, and to perfect his technique—*i.e.* for teaching and for research.

Cinemicrography was first done by Dr. Comandon in 1909 at the suggestion of Dr. Charles Pathé. Dr. Comandon is still working where Pasteur once worked, at Garches, near Paris. His recent films include some on the cells of the blood. In the 1920's, Ronald Canti and Malcolm Donaldson of St. Bartholomew's Hospital, in London, using time lapse technique with cinemicrography, made the famous and lovely films of cancer cells growing and multiplying in tissue culture. The recent adaption of phase contrast microscopy to cinemicrography is an important advance in this field.

The animated cartoon, which started life in a Montmartre cabaret—Le Chat Noir—has proved of great value for teaching health and medicine. During the late war, Disney made a number of Health films and in this country a cartoon film by Giles, on the value of first aid to prevent sepsis, was produced for the Ministry of Information. An excellent explanatory diagram sequence appeared in the recent C.O.I. film, "An operation for Patent Ductus Arteriosus," to explain the arterio-venous shunt in this condition.

Sound and *Colour* have become commonplace in film technique during the last fifteen years. The usefulness of colour in films of surgical operations is obvious, and colour is likely to become the rule for medical teaching films. But the sound film, though a great addition to the methods for medical teaching, has not yet, and probably will never replace silent films for all purposes. The Harvey film, on the Circulation of the Blood, is an excellent proof that even for explanatory as well as illustration films the silent film remains valuable.

Directorial technique in medical films advanced slowly until the last few years. The experience of the British documentary film movement, and the Services experiments in teaching by film have both contributed. The early single shot films and the simple films of the Kodak Medical Library are very different from recent films, such as the Anæsthesia Series made by the Realist

Film Unit for Imperial Chemical Industries. But it is important that in making medical teaching films, the plan and the script of the film shall be designed by medical and teaching experts and not left to the photographic expert, or to the sponsor.

Substandard 16 *mm. gauge film* made an important contribution to the use of the film in medicine. In the earlier days, especially after the 1914–18 war, films were expensive to make and owing to the necessary precautions against fire when using 35 mm. cellulose nitrate film, were awkward to use for teaching. 16 mm. film was much cheaper to buy and more convenient to use: its introduction led to many individual doctors having film records made of their patients or their operative techniques. Few of these films were of great value as they were taken mostly by photographers without medical training who did not understand exactly what it was they were expected to demonstrate in the scenes they filmed.

Besides surgeons, the principle users of film in these early days, and early days they can be called until 1939, were physiologists recording experiments for use in teaching.

The war which started in 1939 marked a new era for the medical film. The necessity for training large numbers of men led to study of newer techniques of teaching and gave a great stimulus to the use of film and film-strip for accelerating medical teaching. In the second place, the Ministry of Information in collaboration with the Ministry of Health made films for the education of the public in matters of health, and these films were made by first-class film units experienced in documentary film work.

The use of film for health propaganda was not new; the Bermondsey Borough Council had a series of films on their health services made in 1935–6; but these war-time M.O.I. films were made to go into wide circulation both theatrical and non-theatrical; and at the same time they set a new standard in production for medical films.

The final step by which the medical film in this country "came of age" was the release in 1945 of the I.C.I. films on anæsthesia. The great importance of these films lies in that they form a planned inter-related series of films and in that they are designed for a specific audience level—that of second year medical students. In the past, the high cost of film making had prevented the making of such an integrated series, and had led to attempts to widen the possible audience. The outcome of such attempts to make films to suit several groups is that advanced audiences are bored by the elementary sections and the less trained audiences are confused by the advanced sections.

FILM IN MEDICAL RESEARCH AND TEACHING.

The great Spanish histologist, Ramon y Cajal, described how he sat for 16 hours at his microscope watching movements of cells. If he had used time-lapse cinemicrography to record the cells over the hours, he could have had his meals and some sleep, and he would also have had a permanent record which he could have inspected again and again.

In such a case the film would be a great help. In other cases it is an essential in research. The work of Franklin and Barclay on the circulation in the sheep embryo, for which they used cineradiography to make records, which they afterwards examined to obtain the information they sought, could not have been done without cinematography. Their film recording sphincter-

like contractions at the foramen ovale of a sheep's heart conveys an impression impossible in any written words.

Photographic and film records of patients before and after treatment can be most instructive: some years ago a child was given a newly introduced drug for muscular dystrophy, a condition in which muscles become weak. He was filmed before and after treatment; the clinical impression received by his doctor was that he was greatly improved, but the film showed there was no change—the doctor's clinical impression was probably influenced by his desire that an improvement should take place whereas the film record suffered no such foibles.

Film records of special types of movements, which can be used later for detailed analysis are of great value: *e.g.* the film, "Movements of the tongue in Speech," of use to phoneticians, or the film "An Infantile Tic," of great interest to child psychologists; an analysis by film of athetosis, chorea, and similar movements might lead to useful results in the understanding of their causation.

Medical Teaching, interpreted in a properly wide sense, includes teaching to a variety of audiences: medical students, doctors in practice, the public, both as children in school and as adults.

As in other spheres of teaching various types of film are recognised.

The *Illustration film*, a straightforward descriptive film; usually brief.

The *Lesson film*, bringing together various items to show their relation to each other and to bring out underlying principles.

The *Training film*, to convey a technique.

The *Background film*, giving a wide review of a subject, with its wider relationships in science and society.

The usefulness of the *illustration film* is very obvious. As it is a record of and not a commentary upon an event it can easily be fitted into existing teaching processes without forcing the teacher to entirely recast his methods.

A film demonstration of a physiological experiment or of a patient never goes wrong: it can be seen by all. Close-up and explanatory animated diagrams can be worked in. Everyone can see "through" the Bronchoscope.

By cineradiography living movements of lungs and limbs become memorable and can be viewed repeatedly without danger of an overdose of X-rays damaging the subject. By cinemicrography the living blood cells can be studied. There can be no harm in directing students thoughts to living tissues—the cadaver and the stained film of blood cells are both dead and so different from the living organism with which the doctor has to deal. Case records on film can be very useful, for it is not always possible to have patients with similar but slightly differing defects, *e.g.* chorea and athetosis, available for demonstration. The film can show the rare case and facilitate its recognition: it can catch for permanent record the signs of the type of disease which to-day is cured so quickly that the abnormality is gone before the student has appreciated it. (Pijper in this connection quotes a malicious remark that the science of medicine has progressed so far that instead of dying of an illness, the same patient can be used over and over again).

The *lesson film* covers a subject in more rounded fashion. In dealing with a typical injury it shows the coalmine where the injury was sustained and the

first aid : in dealing at greater length with the treatment of the wound it refers to comparable other injuries and finally it gives a glimpse of the patient's rehabilitation and restoration to full working capacity.

Background films such as " The World is Rich " and " Enough to Eat," to give one recent and one pre-war example, give a view of the whole wood, where the illustration films showed individual trees. That the importance of such knowledge for the medical student is realised is shown by the recent setting up of chairs in Social Medicine in a number of Universities.

Such background films will reinforce the value of more detailed teaching ; and here it is worthy of note that, as Margaret Vernon has recently shown, without an adequate background of knowledge of a subject, charts of the Isotype variety may be confusing and misleading rather than helpful.

While for the medical student and for the specialist in training, the simple illustration film is of great value, for the qualified doctor who is largely reached through his medical society meetings, the more elaborately worked out lesson film will be indicated. The idea behind the recently released Penicillin film for general practitioners was excellent, and more films on recent advances are needed.

FOR THE PUBLIC, simple physiology can well be taught to school children by films such as the G.B.I. examples, " Breathing," " Circulation," " Digestion." Adults too could well have made for them a series of physiology films. The present Ministry of Health series, " Your Children's Eyes "—" Ears "—" Teeth," are fine models. A series on the physiology of reproduction to help adults to understand menstruation, pregnancy, and the menopause would yield good results over a long period.

Besides films on " How your bodily machinery works " we need others on " How to keep it running smoothly." These will give rules for keeping well and will also tell how to make use of the health services available for oneself and one's family. It is sad that only some mothers (in Scotland less than half) avail themselves of the supplies of cod-liver-oil and fruit juice provided free for their children.

Many people have acquired disabilities ; gastric ulcers, rheumatism and other troubles. They need to be taught how to manage themselves and how to live with their disabilities. The public takes a tremendous interest in its minor disorders, judging by the millions of pounds spent annually on self-prescribed medicines—a good educational programme would seem likely to be welcome and would surely make great use of films, similar to those already well-known—Askey's " The nose has it " ; " Mass Radiography."

THE PRODUCTION OF MEDICAL FILMS.

Before the war there were five sources of films for medical teaching ; films made by amateurs—for example the short illustration films made by Professor Ritchie in Edinburgh ; films made by professional photographers for private individuals—for example many of the films in the Kodak Medical Library ; films sponsored by Commercial concerns for prestige purposes—*e.g.* The Nutrition film of B.C.G.A. and the films of T. J. Smith and Nephew ; a few films made for commercial distribution by G.B.I. and other units ; and films sponsored by official bodies, such as the Central Council for Health Education. In the last six years there has been a great increase in the supply of Health Education films through the activities of the Ministry of Information

acting with the Ministry of Health, and the British Council have made one or two medical films.

Where will they come from in the years ahead? There will be fewer amateur efforts, but many good simple illustrative films are likely to come from medical schools and University photographic units, of which there are now eight or ten in the country. Some commercial sponsoring will continue, but production for profit is extremely unlikely in a field where the market is very limited. The Ministry of Health will continue to have films made for the public and for the information of doctors in practice, and it will presumably make films for nurses as the education of most of the nurses in the country will soon be its responsibility. For films for medical students the outlook is less clear. There is need for an official grant towards this end, given either to the medical schools or possibly to a central Medical Teaching Film Council. The money should come from the University Grants Committee, who have indeed recently been instructed by the Chancellor of the Exchequer to adopt new terms of reference which will enable it to become a policy initiating body in future.

Whatever the source of the money, whether directly from the U.G.C. or from that body through the medical schools, many of the films will be made by professional film units. This is important for it means that the best cinematic technique will be used. In the past it has not always resulted in good teaching aids—many films are over-crowded with facts or not made with a clear conception of the intended audience in mind, and in making medical teaching films, advice at the early, scripting, stage, from someone who knows what can and what cannot be done in a film, is an essential if films are to be efficient aids to teaching.

Medical Education is chiefly done by clinical specialists—in making films it would be wise to get the help of pedagogic specialists. Whether there is any central medical teaching film council or not, films will continue to be made by independent agencies, which is a good thing. The value of the Voluntary Scheme for Co-ordination in Production of Medical Films which the Medical Committee of the Scientific Film Association have in operation is already clear. The same body might well enlarge its co-ordinating activities in co-operation with the Universities Grants Committee and the Medical Schools.

In 1941, Professor J. A. Ryle, discussing the defects of the medical student arriving from the school, said " a higher standard and a more enlightened type of science teaching than obtained in many schools at the present day will be necessary, and it is to be hoped that some training for science masters in teaching method after obtaining their University degree will become obligatory."

It would not be unfair to put " medical " for " science " teaching in the above quotation, and then to read it through again.

Medical teaching in this country, and especially in the hospital, has always laid emphasis on the bedside rather than book teaching, and there is no suggestion that the teacher and the patient can both be done away with and replaced by films. But well thought out visual units (of films, film-strips, specimens and diagrams) will be a great aid to enlarging the experience of the student and doctor.

It is important that during the next few years the curriculum should be analysed and what is suitable for film presentation recognised and then by team work of medical, teaching and cinematic experts, the requisite films

produced. Eventually the impact of the film on teaching is likely to speed up a revision of the curriculum to carry more emphasis on principles of medicine and less on details. Further research on the methods and results of using the film in medical education is needed.

INFORMATION AND DISTRIBUTION AND USE.

In 1944, The Royal Society of Medicine made a generous grant to the Scientific Film Association so that the existing Medical films in this country could be catalogued. A first catalogue giving titles of 800 films with a more detailed summary of 200 of them has been published by A.S.L.I.B. for the R.S.M. and S.F.A. This will be a great help but more is needed. From the title or even from the content summary it is often difficult to tell the quality of a film. To meet this the Medical Committee of the S.F.A. have made a start by publishing a catalogue of the anæsthesia films which gives not only distribution details and content, but also a critical review with assessment of the films usefulness for various audiences. These appraisals are made on a carefully worked out technique by a panel of experts. But so far only 30 of the 800 available films have been dealt with. A grant in aid of such work is urgently needed.

Many films exist in single copies in the possession of the maker. The R.S.M. considered running a central library of medical films but abandoned the idea. The best collection of modern medical and health films at present is that at the Central Film Library of the Central Office of Information. From C.O.I. films and projectors are available without charge. This is very desirable for it is the less well endowed medical and nursing schools that have greatest need for the help of the film in teaching. We need besides this library of more popular films a library which will take and lend out single copies of more recherché films. The National Film Library of the British Film Institute should start a medical section. The principle of national depository for medical films should be accepted without delay or many useful films will be lost forever, but in addition there must be regional sub-libraries, and medical teaching schools will each acquire copies of the films they use frequently.

Some central exchange of information about medical films is needed. The Medical Committee of the Scientific Film Association have done much towards this, but their work has been limited by lack of means, though the recent Governmental Committee's report recognising the value of its work and instituting a grant of the S.F.A. will improve matters in the future.

The importance of such a centre is not only national but international. If we make available to U.N.E.S.C.O. information on, and copies of medical films from this country, we shall be able to tap the medical film resources of other countries. The best medical films of this country compare well with those of other countries. Given the opportunity, our medical and film experts could make a great contribution to medical teaching all over the world.

ENVOI.

In 1945, a copy of the *Evening Standard* carried a headline across a middle page, of how Guy's Hospital students were making medical teaching films. Did anything come of this ?

What is being done here to-day to make use of this aid in teaching, for with so much to learn no aid should be ignored. Professor Whillis has long experience of making anatomical teaching films. The University or University Grants Committee should give him an opportunity to make more. Sir Charles Symonds, Mr. Hedley Atkins, Mr. Batchelor, the Department of Child Health have had films made in the last year. Our excellent Department of Medical Illustration have contributed greatly to these.

And in the use of films, the Nurses' Training School, the Dental School and the Medical School, are as enterprising or more so than any other schools in the country. With increasing experience of this medium, we hope to be able to give useful help in indicating what is needed and what further films should be made next.

Guy's Diary

FEBRUARY

ACADEMIC

Exhibition. Surgical Dept. "Twenty Questions."

14th. 1.00. Mr. Atkins. Clinical Lecture. "Ulceration of the Skin."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. J. K. Martin. Dept. of Child Health. Postgraduate Lecture. "Constipation."

15th. 12.00. Dr. M. J. McArdle. Neurological Demonstration. Preclinical Classroom.
1.00. Mr. Blackburn. Clinical Lecture. "Carcinoma of the Stomach."
5.00. Dr. Bishop. Endocrine Lecture. "Diseases of the Thyroid Gland." Preclinical Classroom.

16th. 1.00. Dr. Waterfield. Hæmatological Lecture. Hæmatology Dept.
4.45. Guy's Science Club. "The Use of X-rays in Research." Mr. T. H. Hills. Staff Common Room. (Tea 4.30).

17th. 1.00. Professor Spurrell. Clinical Lecture. "Pain."
4.30. X-ray Meeting. Gordon Museum.

18th. 1.00. Sir John Conybeare. Clinical Lecture. "Dysphagia and Diseases of the Œsophagus."
2.15. Medical Dept. Combined Round. Preclinical Classroom.

21st. 1.00. Professor H. L. Sheehan, M.D., F.R.C.P., Professor of Obstetric Pathology, University of Liverpool. Clinical Lecture. "The Pathology of Eclampsia and Pre-Eclamptic Toxæmia."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

22nd. 1.00. Sir Charles Symonds. Clinical Lecture.
5.00. Dr. Bishop. Endocrine Lecture. Preclinical Classroom.

23rd. 1.00. Dr. Waterfield. Hæmatological Lecture. Hæmatology Dept.

24th. 1.00. Mr. Wass. Clinical Lecture.
4.30. X-ray Meeting. Gordon Museum.

25th. 2.15. Medical Dept. Combined Round. Preclinical Classroom.

26th. 10.00. Surgical Dept. Clinico-Pathological Meeting. Anatomy Theatre.

28th. 1.00. Mr. Carter Braine. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. D. W. Beynon. Department of Child Health. Postgraduate Lecture.

SPORT

18th. Rifle Club "A" Team *v.* St. Marylebone Officers' Guild.

19th. Rugby XV. *v.* Aberavon (H.O.P.).
Hockey 1st XI. *v.* United Services, Portsmouth (H.O.P.).
Hockey 2nd XI. *v.* United Services, Portsmouth (Away).

22nd. 7.15. Boxing Tournament, Seymour Hall, W.1. (Guy's *v.* St. Mary's Hospital).

25th. Rifle Club "A" Team *v.* "W" Div., M.S.C.
Rifle Club "B" *v.* 31st County of London H.G. "B."

26th. Hockey 1st XI. *v.* Sevenoaks (Away).
Hockey 2nd XI. *v.* Sevenoaks (H.O.P.).

Reviews

A Text Book of Surgery for Dental Students. By G. PERCIVAL MILLS and HUMPHREY HUMPHREYS. 5th Edn. Arnold. *Price* 18*s.*

MILLS' and Humphreys' book needs no introducing to most dental students. This new edition brings it up to date and can be thoroughly recommended. As a book of this kind must of necessity be brief, reference to one of the general textbooks of surgery should be made when needed.

A.J.D.

Synopsis of Physiology. By A. RENDLE SHORT, C. L. G. PRATT and C. C. N. VASS. 4th Edn. *Price* 20*s.*

THIS book presents in the form of notes much of the detail of human and animal physiology. It is intended for the use of students of all grades up to those taking the Primary Fellowship. For those who have a thorough grounding in general physiological principles it provides a convenient and well-indexed source of much out of the way information.

J.N.H.

Some Lessons of the Exchange, 1948

By H. J. B. ATKINS, D.M., M.Ch., F.R.C.S.

(*Continued*)

2. *Liver and Gall Bladder.* Some account of the work on cirrhosis of the liver has already been given (*v.s.*), but physiological studies of this organ are occupying many workers here. At the Halsted Club for instance, Dr. Varr read a very instructive paper on liver regeneration. He found that recovery of liver protein in dogs, hitherto fed on a low protein diet, was accelerated by giving fat with the excess protein. This observation tallies with the modern view that patients with liver disease should not be deprived of fat, especially uncooked fat, which they are usually able to digest.

At the same meeting, Dr. Kirby described a 'choledochoscope,' though 'choledochophone' would have been a more appropriate name. This instrument consisted of a curved common-duct probe, the tip of which was articulated so that it moved less than a thousandth part of a millimetre on coming into contact with a hard object. Attached to this tip and running back through the probe was a fine wire, the other end of which made contact with a quartz crystal and converted the slightest vibration into sound. By amplifying the sound, very distinctive responses could be obtained when the tip of the instrument was made to impinge with even the lightest touch on objects of different consistencies. The "clink" which was emitted when a gall-stone was touched was quite characteristic and the instrument had already proved of value in locating stones within the common duct.

At the Hopkins they operate on cases of acute cholecystitis as a routine. One evening one of the Residents, Dr. Muller it was so far as I can recall, came up to me and said that they had just taken in an "acute gall-bladder," and had arranged for me to operate on it in half-an-hour. He said this with such conviction and with such pride at having at last secured for me a gall-bladder which he had wanted to see me do, that I had not the moral courage to say "No, this is not my practice—I like to treat cases of acute cholecystitis conservatively and wait until the inflammation has settled down and the operation is easier." I did, however, hazard this opinion while the case was being draped. "But," he said, "it is much easier to do a cholecystectomy in the acute stage, the œdema does most of the dissection for you." So, in this case at least, I certainly found it. The cystic duct was short, stumpy and dangerous—but the œdema showed it to me; the cystic artery came in a curious way off the right hepatic artery, which was tortuous and mimicked the cystic artery, but the œdema at once revealed it, and the dissection of the gall-bladder from its bed in the liver was simply a matter of cutting through avascular œdematous tissue a quarter of an inch thick. I think I shall not have to be quite so dogmatic in the future. This case too was a reminder of the pitfalls of surgery. At the conclusion of the operation I removed the appendix as a routine, but on the fourth post-operative day when she was about to be discharged home, a routine pelvic examination revealed a pyosalpinx, and she was transferred to the gynæcological service, I suppose for at least another forty-eight hours to have this fixed!

I watched Dr. Firor operate on a case in which the common-duct had been nearly completely removed during an operation for cholecystectomy in some Central American republic. He was able to bring the remains of the duct together over a T. tube, after literally hours of careful dissection, in a mass of cartilagenous-like tissue, to find the ends.

At a staff round a case of subacute pancreatitis with gallstones was shown. The serum amylase was over 1,000 mg. per cent., a test upon which the greatest reliance is placed, and an X-ray of the gall-bladder showed this to be packed with stones. Neither in this case, nor in another case of acute pancreatitis which I saw was there any pain referred to the back. How often does pain in the back accompany acute pancreatitis? Asked for my opinion on treatment, I said that I would remove the gall-bladder and if necessary explore the common duct, but no more. Dr. Blalock agreed with this, but toyed with the idea of opening the duodenum and inspecting, even incising the ampulla of Vater. He would not, he said, in this case advise sympathectomy, vagotomy, ligature of the pancreatic ducts or pancreatectomy, thereby epitomising for us the operations which have been at one time and another advocated in America for pancreatitis.

3. *Lung.* Although an enormous amount of lung surgery is performed by Dr. Rienhoff and by the Resident staff I only had the opportunity occasionally to watch this; there was so much else to see and do which was of more consequence to me

personally. Nevertheless, the Brock bronchus clamp was highly approved, as incidentally was the Ogilvie instrument rack, which I used in all my operations, and also the Rodney Maingot gastrectomy clamps, which I had brought over with me.

At one clinic I had an opportunity of listening to Dr. Blalock discoursing on the somewhat unusual simple adenoma of the bronchus. Controversy had raged for some years as to the best method of dealing with this lesion. Some surgeons had maintained that it was essentially a benign lesion and could adequately be exorcised by bronchoscopic diathermy, but now most followed Evarts Graham in the belief that such lesions were potentially malignant and should be treated by lobectomy or even, in some cases, by pneumonectomy. There were also interesting pathological studies being pursued, which related these so-called adenomata of the bronchus to the mixed salivary tumours, both in their morphological characteristics and clinical behaviour.

Dr. Blalock later spoke about the radical treatment of the solitary secondary deposit in the lung, illustrating his remarks with a case where an isolated rounded shadow, far from the mediastinum in the X-ray of the chest of a woman with blood in her urine, indicated the strong probability of a secondary deposit from hypernephroma. He concluded that the prognosis of pneumonectomy in such cases varied with the length of time elapsing between the first symptoms of the primary and the appearance of the secondary in the lung. When the interval was a long one, the prognosis was good. He cited two cases of carcinoma of the cæcum originally under the care, the one of Dr. Firor and the other of Dr. Harvey Stone, who had survived operation for a pulmonary secondary deposit for five and seven years respectively.

4. *The Thyroid.* The mountains of West Virginia provide the Hopkins with their endemic goiterous region, and I had the opportunity of operating on two massive nodular goitres with retro-sternal prolongation. Their views on cutting the strap muscles coincides with ours. That is, no fetish is made of it one way or the other; if it should be simpler that way, then they are cut.

Much interest centres round the so-called "aberrant thyroid" or thyroid tissue situated high in the neck laterally. There is no equivocation about their position in regard to this lesion. Briefly it is this—there is no such thing as an "aberrant" lateral thyroid. All these lesions are glandular deposits from papillary adenocarcinoma within the substance of the thyroid gland itself. The finding of thyroid tissue in this high situation laterally is an indication for complete unilateral thyroidectomy and, if this lobe of the thyroid is sectioned serially, a papillomatous adenocarcinoma varying in size from a millet seed to a golf ball will be found in a hundred per cent. of cases.

While I was there Dr. Ravitch removed a cyst-like mass from the region of the digastric triangle, this was thought to be a branchial cyst and frozen section seemed to confirm this. When the definitive section report was received three days later, however, it was found to be an adenocarcinoma of the thyroid. Dr. Ravitch then went back and removed the lobe of the thyroid on that side, and a small carcinoma, the size of a pea, was found in the upper pole. Dr. Seed, who was visiting from Chicago, said that in his experience recurrence nearly always occurred eventually, sometimes after as long an interval as fifteen years, and always in the same side of the neck. He did not therefore feel that there was any indication for total bilateral thyroidectomy in such cases.

For the benefit of the Halsted Club, Dr. Rhoads of Philadelphia operated on a solitary adenoma of the thyroid. He said that the view of their pathologist was that 11 per cent. of such adenomata were potentially malignant, and that this constituted an incontrovertible argument for their removal.

5. *The Breast.* As might be expected, some of the most meticulous and delightful surgery at the Hopkins is seen in the performance of radical mastectomy. The operation nearly always takes two hours and sometimes as long as four. A wide area of skin is removed so that skin-grafting with the Padgett's dermatome is almost the rule. Skin flaps are flayed thinly, and their results are fine examples of radical cancer surgery. A frozen section is taken almost as a routine, and is certainly helpful on occasions, especially as the pathologist concerned has made a life-time study of the technique of production and the interpretation of these sections.

I watched many "Halsteds" performed, and learnt much from them. One interesting case of Dr. John Finney's brought out a number of points of technique:

a. The breast, always a difficult part to "towel up," was draped with two large towels split for half their lengths. One, coming up from below, enclosed the operating field between its 'flaps'; the other, coming from above, had one flap

overlapping the lower towel on the medial side of the field, whilst the other flap was passed under the outstretched arm and covered the edge of the table. The arm was then enclosed in a 'pillow-case' type of towel.

b. The field, after the breast had been removed, was swilled with warm saline solution, which washed away clots and revealed minute bleeders for ligature.

(Fig. 6)

c. Where there was any degree of tension the "pulley stitch" (Fig. 6) was used. A stitch which distributed evenly the tension over a considerable width of skin.

d. The whole incision was stitched up with subcuticular silk threaded on a round-bodied half-circle needle (Bloodgood's needle) and no stitches were passed through the skin itself. In this way the flaps came together with exact apposition, but without any strangulation of the vessels in the skin itself.

e. A rubber catheter was inserted instead of a drain through the lateral flaps and this was aspirated every two hours after the operation so that there was no fluid collection, and the flaps were sucked down on to the deep tissues and behaved as whole-thickness skin grafts.

(To be concluded)

House Appointments

FEBRUARY 15th to MAY 31st, 1949.

GUY'S.

To—	A.H.S.	H.S.
Sir Heneage Ogilvie and Mr. Blackburn ..	Mr. H. D. A. Hope	Mr. C. H. Talbot (3 months)
Mr. Massie and Mr. Wass	Mr. N. H. Porter	Mr. R. Merryweather (6 months)
Mr. Eckhoff and Mr. Lawrie	Mr. R. D. Allen	Mr. D. H. Keller (3 months)
Mr. Atkins and Mr. Glover	Mr. J. D. Williams	Mr. W. F. W. Southwood (3 months)

O.P.O.		R.O.s
Mr. D. C. Deuchar	1.2.49—30.4.49	Mr. J. M. Thomas*
Mr. J. Vance	1.3.49—31.5.49	Vacant
Mr. T. E. Jeffreys	1.4.49—30.6.49	Mr. R. D. C. Hart
Mr. A. A. Craigen		

To—	H.P.
Sir John Conybeare and Dr. Hardwick	Mr. E. W. Graham (3 months) Mr. M. Hatton (6 momths)
Dr. Boland and Dr. Baker	Mr. R. A. Miller (3 months) Mr. E. F. Soothill (6 months)
Dr. Hampson and Dr. Kauntze	Mr. C. L. Joiner* (3 months) Mr. K. M. Citron (3 months)
Dr. Douthwaite and Dr. Mann	Mr. T. R. L. Finnegan* (6 months) Mr. D. F. V. Brunsdon* (6 months)

NEUROLOGICAL H.P.
Mr. J. E. Blundell*

CHILDREN'S H.P.
Mr. N. K. Macrae-Gibson*
Mr. E. G. Cook*

NOSE, THROAT AND EAR H.S.
Mr. D. F. N. Harrison

ORTHOPÆDIC & FRACTURE H.S.
Mr. P. Chadwick

DERMATOLIGICAL H.P.
Mr. J. K. Morgan*

OPHTHALMIC H.S.
Mr. G. H. Levien

GENITO-URINARY H.S.
Mr. C. R. Neve* (3 months)

H.S. TO THORACIC UNIT
Mr. K. M. S. Hume

ORPINGTON	E.N.T. House Surgeon	Mr. J. B. F. Boyle
PEMBURY	House Surgeon	Mr. D. N. H. Owen
SOUTHERN	General Duty House Officers	Mr. K. A. Baker Mr. P. T. C. Rowan
JOYCE GREEN	House Surgeon	Mr. A. Mendoza
	House Physician	Mr. W. P. Gurassa*

* Ex-Service Medical Officer.

Sport

RUGBY

GUY'S *v.* DEVONPORT SERVICES

at Devonport. Won 16—3.
29th January, 1949.

I have not seen Guy's play so well for a long time as they did when beating the Services 16—3 at Devonport. There were doubts about a few of the players until shortly before the start but eventually they lined up as published. On paper, Devonport had a formidable side—notably the scrum where Hosking and Meredith formed a second row which can be second to none in the country.

Guy's kicked off and it became abundantly clear that it would need more than a good side to hold the Services. Time and time again only the most gallant falls checked foot rushes by the Services pack. Clever picking up and accurate touch-kicking notably by Brunow however held the line intact and although the Services scored with a penalty goal, Guy's changed over to play with the wind and the sun only 3 points down.

At this stage the game had been hard and fierce, but had given no indication of the brilliant football which was yet to thrill the large crowd during the second half.

Almost from the kick-off Guy's went into the attack and a series of passing movements resulted in Heber touching down far out to level the score. Once again from the kick-off the Services forwards bore down on the Guy's line—unfortunately over running themselves with a scrum resulting. Guy's heeled and Large who was throwing out beautiful passes sent Brunow away blind. Beating his man he passed out to the wing and then in a scintillating bout of passing in which at least ten men handled Guy's were almost over and only a desperate tackle checked Gibson—Guy's, however, were there in force and to Large fell the honour of the final pick-up to score a wonder try. After this there was no stopping Guy's—they had the Services pack shackled and the three-quarters so bewildered that their passing became very wild. Birch added two further tries both after some clever handling, and both of which were converted, one by Brunow and one by Le Clus.

Verbal bouquets cannot do as much for the team morale as this brilliant victory. I cannot, however, finish without mentioning a few particular people. Brunow—despite rumours of "ill-health" —can never have led his team so well and his individual brilliance remains as always dominant.

Gwyn Davies stood fiery head and shoulders above the international fare on view: no one worked harder or achieved so much amongst the forwards as he. The wing forwards body checking more than usually had the Services' line well controlled, and Kirkbride, a comparatively new member, put in gallant work.

Continue like this Guy's and the Cup cannot fail to be yours.

HOCKEY

GUY'S *v.* BIRMINGHAM UNIVERSITY

at H.O.P. Won 5—2.
7th January, 1949.

This was the first of two annual fixtures and the first game of Birmingham University's winter tour, during which they play several Southern teams. After lunching in the "Spit," the visitors went on to H.O.P. where little rain had fallen and the pitch was in good condition.

Rivalry was intense and the game began at a fast pace. Then D. Blake, running through to score on his own, put Guy's in the lead. Two more goals followed quickly, one for each side, so that Guy's were leading 2—1 at half-time.

The second half was fast and open. The Hospital forwards, swinging the ball about well, soon gained an ascendancy over the defence which resulted in two further goals. With five minutes to go, and both teams flagging, the Birmingham inside-right took a good pass and scored with a high shot. Then, from the resulting bully-off, a movement begun by S. Earl and D. Blake was well finished by C. Opie who scored the last goal.

Team: F. Walker, G. Danford, N. Parker, C. Robinson, E. A. Murray (Capt.), L. Mackey, A. Blower, D. Blake, S. Earl, C. Opie, R. Hodson.

GUY'S *v.* SOUTH SAXONS

at H.O.P. Won 4—1.
8th January, 1949.

With a combined 2nd and 3rd XI playing away at Hastings, Guy's 1st XI had the advantage of playing at home, and on a pitch that suited the tactics of their forwards and made sound defensive play possible.

With honours even in mid-field, Guy's victory was due to the forwards who took advantage of every opportunity.

Team: As for Birmingham University, except D. McGill for L. Mackey.

The following were selected to play for United Hospitals *v.* Essex County "A," on Sunday, December 12th, 1948; result, won 7—1:—

D. V. Duckworth, D. Blake, S. Earl, C. Opie, R. Hodson, E. A. Murray, N. Parker.

GUY'S *v.* HENDON

at Hendon. Won 3—2.
15th January, 1949.

A heavy, wet pitch made clean passing and ball-control difficult. The Hospital had more of the game and, though scoring was never easy, the forceful play of R. Hodson (outside-right) made the openings which helped the forwards to victory.

Shortly after the start, a Hendon clearance was followed up and resulted in a goal for them. C. Opie equalised for Guy's a little later. The home team continued to press hard and their second goal came just before the interval. (2—1).

The Hospital forwards then took advantage of the drier half of the field and, after some pressure, D. Blake equalised. Some mid-field play followed. Then from a melée in the Hendon goal-mouth, D. Blake scored a second time to give Guy's the lead. Hendon made several attempts to equalise, but some good spoiling tactics by the defence contributed to yet another Hospital victory.

Team: As for Birmingham University.

GUY'S *v.* WOOLWICH POLYTECHNIC

at H.O.P. Won 3—1.
22nd January, 1949.

Guy's won this fast game on fairly firm ground because their passing was better and a well-swung ball enabled their forwards to vary the attack.

Although the visitors forced two corners in the first ten minutes, they were unable to score, and some quick clearances soon put the Hospital on the attack. C. Opie, taking a pass from the left, dribbled past a defender to score the first goal. But the forward line, at this point, was working less smoothly than usual and some good movements went awry near the goal.

Guy's had the better of the second half. S. Earl, making a solo run to the goal line, cleverly reverse-passed for C. Opie to score with a scoop shot (2—0). Woolwich Polytechnic now rallied strongly and, after some pressure, the centre-forward broke away to score from the top of the circle. Guy's again passed to the attack and D. Blake made quite sure

of the match with a fine drive into the net from a long corner.

Team : As for Birmingham University except D. V. Duckworth for A. Blower.

GUY'S *v.* UNIVERSITY COLLEGE, LONDON

at Shenley. Won 5—1.
26th January, 1949.

This was a return match, the first having been won by Guy's (2—0) at H.O.P. earlier in the season.

The College were no match for a Hospital team who took full advantage of the fairly firm going. F. Walker, in goal, was seldom tested. The half-backs often smothered attacks which had only just begun and E. A. Murray, in particular, played a fine forceful game. The forwards' tally might have been higher had their shooting in the closing stages been more accurate.

It was ten minutes or so before C. Opie scored after a free hit near the circle. Guy's backs and halves were getting the better of mid-field play, when S. Earl scored the first of two spectacular goals. He took a pass from the right, in the air, and flicked the ball into the net.

There were more attacks following the interval. First C. Opie scored from a hard cross-pass by H. Meyer. S. Earl followed with another fine mid-air shot in the goal-mouth (4—0). The College forwards, never despairing, tried yet again to break through and succeeded, their centre-forward pushing the ball past the onrushing goalkeeper. Then, a few minutes from time, S. Earl completed another hat-trick by pushing the ball past the keeper, caught well out in front of goal.

Team : F. Walker, G. Danford, P. Kapff, H. Meyer, E. A. Murray (Capt.), W. Dobson-Smyth, D. V. Duckworth, D. Blake, S. Earl, C. Opie, R. Hodson.

GUY'S *v.* EALING DEAN

at Ealing. Won 3—0.
29th January, 1949.

A soft, heavy pitch made for poor hockey. Features of the game were the dashing runs of S. Earl, who scored all three goals, and the good covering play of half-backs and backs. The hitting was necessarily hard on such ground and the forwards often had to rely on hit-and-follow tactics to press home the attack.

Ealing had all the play for the first fifteen minutes. Three corners were awarded and they narrowly missed scoring. Then, rather against the run of play, R. Hodson centred well for S. Earl to score. Guy's were now warming up and, for a time, honours were even. But, on heavy ground, the unexpected can occur in hockey, and two goals came in quick succession. C. Opie took the ball through, passed from an acute angle, and S. Earl was well placed to flick the ball home. Soon afterwards a shot from R. Hodson rebounded from the keeper's pads and S. Earl caught the ball in mid-air to score again a lucky but brilliant shot.

Guy's had more of the ball after the change-over. At least four corners were awarded and, from one of these, a goal was disallowed for sticks. The Ealing forward line appeared to lack balance and the Hospital defence had no difficulty in smothering any promising move.

Team : F. Walker, G. Danford, R. Sonnenfeld, C. Robinson, E. A. Murray (Capt.), L. Mackey, D. V. Duckworth, H. Meyer, S. Earl, C. Opie, R. Hodson.

LONDON UNIVERSITY INTER-COLLEGIATE CUP
SEMI-FINAL ROUND
GUY'S *v.* KING'S COLLEGE, LONDON

at Mitcham. Won 3—1.
2nd February, 1949.

The game was played at a fast pace on good ground. Such was the enthusiasm shown throughout, that at no time did either team look like getting the upper hand. There were thrills and spills, for King's College were most unfortunate to lose a good inside left, who had to retire with a shoulder injury at a time when he was most needed. Guy's won because their defence stood more firm in the face of pressure and the forwards took better advantage of scoring chances.

After several fruitless attacks Guy's lost the initiative and the College twice came near to scoring. The situation was relieved by some good first-time clearances and the Hospital again pressed hard. Four corners were unavailing. Then, another sudden attack caused a defender to clear across the goal-mouth. S. Earl intercepted and scored.

The change-over brought more lively attacks by the College. They repeatedly stormed the Hospital circle and their outside-left eventually scored the equaliser with a scoop. It was at this point that they lost a man.

For a Cup match this is no mean handicap and it was not surprising for the initiative to pass to Guy's. A shot from R. Hodson went off a defender's stick, and S. Earl helped the ball over the line for the second goal. A third soon followed when D. Blake ran through to push the ball past an onrushing goalkeeper.

But King's never tired and were attacking to the last. The Guy's defence, and especially R. Harper (a reserve), therefore deserve great credit for consolidating a good win.

Team : C. Bishop, G. Danford, R. Harper, C. Robinson, E. A. Murray (Capt.), L. Mackey, D. V. Duckworth, D. Blake, S. Earl, H. Meyer, R. Hodson.

GUY'S *v.* LLOYDS BANK

at New Beckenham. Won 4—3.
5th February, 1949.

This was perhaps the most enjoyable game this season. Played on a hard pitch in bright sunshine, it was also the hardest fought and won.

Lloyds began at a cracking pace. Their passing was better and they were quicker on to the ball. They penetrated the Hospital defence several times and it was only some first-time clearances which prevented them from scoring. Guy's now rallied to attack strongly but the forwards were slow on the ball and missed two scoring chances. Eventually, S. Earl took a pass from the right in the centre of the circle to score first. Lloyds, now spurred to further efforts, attacked continuously for ten minutes and scored twice in this time to take the lead. Soon afterwards, their inside-right ran through to score again with a cross-drive (1—3). A fourth goal was disallowed for sticks.

The Hospital began the second half facing defeat and a home team who were right on top Then followed one of the finest displays of attacking hockey, kindled by a grand team spirit, that Guy's have shown since the war. Each man played twice as hard. Each ran to meet the ball, to tackle hard, to pass quickly and to be relentless in attack. The Lloyds goal was repeatedly stormed for the last twenty minutes, and it was a just reward for "getting stuck in" that three goals were scored to give Guy's a great victory. S. Earl, C. Opie and D. Blake were the scorers.

This leaves one in no doubt that the standard of hockey at Guy's has risen to a point at which the 1st XI. is on a par with the best clubs in London and the South. There is now a real need of better fixtures, and a second hockey pitch, for a club whose record surpasses that of any of its predecessors for twenty-five years.

Team : As for Ealing Dean except D. Blake for H. Meyer.

The following is the Club record of matches played this season :—

P.	W.	D.	L.
19	18	1	0

GUY'S HOSPITAL SQUASH RACKET CLUB

On Friday, February 18th next, at 6.0 p.m., the present Guy's Hospital Team will play against the 1932 Guy's Hospital Team, under the captaincy of Dr. Charles Baker. Visitors are welcome.

RIFLE CLUB

1st TEAM *v.* STAFF

November 5th.

The Club was honoured on the evening of November 5th by the presence of a team of Members of the Staff.

The Club team won by 668—628. Top scorer for the staff was Dr. Meekleburg with 99. A. Jennings was top scorer with 98 for the Club.

Members of the Staff present were :—Mr. Eckhoff (President), Dr. Carter-Braine, Mr. Stamm, Mr. Kenshole, Dr. Meekleburg, Dr. Hutton, Mr. Guerrier and Mr. Drew.

A dinner was held later in the evening at the "Wheatsheath."

THE CITY OF LONDON RIFLE LEAGUE

Div. 10.

TABLE UP TO JANUARY 14th.

	F.	W.	D.	L.	P.
1. Central Parks "A" ..	12	11	0	1	22
2. Lewisham "C" ..	12	10	0	2	20
3. Guy's Hospital "A" ..	12	9	0	3	18
4. Alleyn O.B. "B" ..	12	8	0	4	16
5. Marylebone "B" ..	12	8	0	4	16
6. "W" Div. M.S.C. ..	12	8	0	4	16
7. Harland & Wolff "A"	12	5	0	7	10
8. Mitcham and Tooting "B"	12	4	0	8	8
9. G.P.O. "E"	12	4	0	8	8
10. City of London Special Constabulary ..	12	3	0	9	6
11. St. Marylebone Officers' Guild	12	2	0	10	4
12. Polytechnic "B" ..	12	0	0	12	0

(N.B.—2 pts. for a win)

CHRISTIAN MEDICAL EXHIBITION

Every London Teaching Hospital is having an Exhibition of Christian Medical work overseas, sponsored by the S.C.M. during this month, and it is coming to Guy's from February 25th to March 1st.

The Exhibition is being held in the Gordon Museum and should be of interest to all members of the Hospital. It shows general social conditions in Africa and India—so much the cause of Tropical diseases—and then deals with the Prevention and Treatment of such diseases by various drugs that have been supplied by several well-known firms.

During the four days of the Exhibition these films will be shown, one of them showing a Cataract Operation.

A.D.T.,
Hon. Sec.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

*Applications are invited for the post of **Resident Anæsthetist** to Guy's Hospital. Duties to commence on 14th March, 1949. Salary at the rate of £350 per annum with resident emoluments. Applications should be lodged with the Superintendent, Guy's Hospital, S.E.1, not later than 25th February, 1949.

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*Applications are invited for the appointment of two **Assistant Anæsthetists** to Guy's Hospital, with attendance on four sessions per week, with remuneration at the rate of £200 per annum per session subject to revision when the new Ministry of Health scales of salaries are published. The appointments are of Consultant status, and applicants are required to hold higher qualifications in their specialty. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 14th March, 1949.

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*Applications are invited for the appointment of **Assistant Physician to the Dermatological Department** of Guy's Hospital (part-time), with attendance on two sessions per week with remuneration at the rate of £200 per annum per session, subject to revision when the new Ministry of Health scales of salaries are published. The appointment is of Consultant status, and applicants are required to hold a higher qualification. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 28th February, 1949.

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*Applications are invited for the appointment of **Assistant Physician to the Department of Psychological Medicine** of Guy's Hospital (part-time), with attendance on not less than three sessions per week for adults and children, with remuneration at the rate of £200 per annum per session, subject to revision when the new Ministry of Health scales of salaries are published. The appointment is of Consultant status, and applicants are required to hold higher qualifications in their specialty. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 28th February, 1949.

Applications are invited for the appointment of **Lecturer in Chemical Pathology.** Salary £650 rising to £800 per annum, with superannuation and family allowance. A medical qualification is desirable but not essential. Date of commencement of the appointment to be arranged.

Application, giving the names of three referees, should be made on a form to be obtained from the Dean of the Medical School, not later than 8th March, 1949.

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*In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of members of the Board of Advisory Appointments Committee will lead to disqualification.

UNIVERSITY OF LONDON

APPOINTMENT OF EXAMINERS, 1949.

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

Pharmacology.

Dr. J. M. Robson

SECOND AND THIRD EXAMINATIONS IN DENTAL SURGERY.

Prosthetic Dentistry (including Properties of Dental Materials).

Prof. H. R. B. Fenn

Pathology and Bacteriology.

Dr. S. J. de Navasquez Prof. M. A. Rushton

Pharmacology :—Mr. K. Hooper.

Medicine :—Dr. C. G. Baker.

Dental Surgery and Operative Dental Surgery.
Mr. G. T. Hankey Prof. W. E. Herbert
Orthodontics :—Mr. R. E. Rix.
Surgery :—Mr. N. L. B. V. Eckhoff.

EXAMINERS FOR MEDICAL DEGREES.

Forensic Medicine :—Dr. J. H. Ryffel.
Medicine :—Dr. E. R. Boland, Dr. W. N. Mann.
Obstetrics and Gynæcology :—Mr. F. Cook.
Pathology :—Prof. G. P. Wright.
Surgery :—Mr. S. H. Wass, Mr. G. Blackburn.

PASS LIST

M.D.

December, 1948.

Branch I.—(Medicine).

A. G. C. Cox H. A. Leggett
C. W. Kesson

Branch V.—(Hygiene).

R. E. Lane

M.S.

December, 1948.

Branch I.—Surgery.

S. I. Green

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES.

December, 1948.

J. K. Anderson C. B. H. Owen
E. J. Artes J. D. Pryce
A. G. F. Dominick T. Smith
A. Gibson I. L. Thomas
G. L. Hunter T. A. Thorburn
L. R. Jenkins R. W. Willcocks
P. A. T. Martin

The following External Candidates have completed exemption from First Medical :—

F. A. F. Biddle D. P. Fawkner
G. J. R. Clarke K. Scott

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

December, 1948.

Honours.

*S. R. W. Powell.

* Distinguished in Medicine, Pathology and Bacteriology, and Orthodontics.

Pass List.

B. G. E. Donner S. C. J. Pink
H. E. Dyer T. C. J. Price
S. P. Gill J. G. Whitelegg

Supplementary Pass List.

The following student has passed in Group I. :—

G. B. Morris

SECOND EXAMINATION IN DENTAL SURGERY—PART I.

December, 1948.

R. G. K. Burston S. Shindler
M. F. Gill J. S. Tisdall

SECOND EXAMINATION IN DENTAL SURGERY—PART II.

December, 1948.

D. M. J. Lyons K. F. C. Muncey

ROYAL COLLEGE OF PHYSICIANS OF LONDON

M.R.C.P.

January, 1949.

D. Davies R. T. Parkin
J. F. Delafresnaye L. G. Scott
D. E. Meredith D. Q. Trounce

CONJOINT BOARD

January, 1949.

D.L.O.

M. D. Cremin.

D.P.M.

F. L. D. Young.

D.M.R.—D.

P. H. K. Gray.

D.P.H.

F. O. Potter.

FINAL EXAMINATION.

January, 1949.

Pathology.

*R. D. Allen K. M. Herd
D. L. Blundstone J. C. Hopkins-Husson
J. E. Breese L. C. Kreeger
I. B. Davies *J. D. Williams
J. B. Gayes S. A. A. Zaidi

Medicine.

*R. D. Allen S. S. Grové
*J. B. F. Boyle L. C. Kreeger
B. G. B. Christie P. G. W. A. Lommerse
D. G. Chalmers B. Plant
I. B. Davies *C. W. Taylor
F. G. Ellis *J. D. Williams

Surgery.

*L. C. Bellsham-Revell *P. Ronchetti
*J. B. F. Boyle *P. T. C. Rowan
P. R. Chalk *G. W. Scott
*O. F. Conrau *A. Southwell
*A. T. T. Forrester O. L. Thomas
*D. H. Griffiths *R. D. Walsh
*D. S. Hurwood *A. J. Walters
*A. H. Mendoza

Midwifery.

E. Beswick G. A. Lawrence
G. Canty J. C. Lindsay
C. J. Frederick L. W. Mackey
H. R. E. Gillespie D. S. Noble
G. A. L. G. Glazebrook A. H. Phillips
*A. K. Hancock M. Rayne
E. M. Hume *C. W. Taylor
*D. S. Hurwood S. A. A. Zaidi
J. A. B. Jones

* Have completed the examination.

PRE-MEDICAL EXAMINATION.

December, 1948.

Chemistry, Physics and Biology.

A. d'A. Fearn.

Chemistry.

R. B. A. Barr M. F. Jones
F. L. Brown F. H. Trist
W. A. B. Cahill J. T. Williams
A. B. Grantley-Smith J. F. Wylie

Physics.

D. K. Hutchinson K. E. G. Peters

Elementary Biology.

B. S. H. Cornhill M. F. Jones
J. G. Davies D. U. E. Miller
D. P. Fawkner J. F. Wylie

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

Surgery : J. S. G. P. Stapleford, E. J. Stafford, N. H. Porter.

Pathology, Bacteriology and Forensic Medicine : M. P. M. Coupland, N. H. Porter, D. Redpath, *E. J. Stafford.

Medicine : M. P. M. Coupland, F. W. Retief, *E. J. Stafford, M. P. Cardew, *N. H. Porter.

Midwifery : N. H. Porter, *E. J. Stafford.

* Has completed the examination.

APPOINTMENTS

Dr. Maurice Partridge has been appointed Assistant Psychiatrist to St. George's Hospital.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Dr. C. F. Hawkins has been awarded a Mackenzie Mackinnon Research Fellowship by the Royal College of Surgeons of England.

UNIVERSITY OF LONDON

Dr. C. Keith Simpson has been appointed part-time reader in Forensic Medicine at Guy's Hospital Medical School.

C. B. Allsopp, Ph.D., has been appointed reader in Physics at Guy's Hospital Medical School.

ROYAL SOCIETY OF ARTS

On Thursday, 13th January, 1949, Sir Bennett Hance delivered the Sir George Birdwood Memorial Lecture before a meeting of the Royal Society of Arts (India, Pakistan and Burma Section) on "The Development and Goal of Western Medicine in the Indian Sub-Continent."

AWARDS

Mentioned in Dispatches.

Major D. F. Freebody, Captain A. Batty Shaw, in recognition of gallant and distinguished services in Palestine.

Insignia of Chevalier of the Legion of Honour.

Captain B. J. Fowler, R.A.M.C., Surgeon at the Military Hospital in Tobruk, in recognition of valuable services rendered by him on the occasion of a mine explosion in April, 1947.

PASS LIST

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

January, 1949.

Surgery : N. H. Porter.
Medicine : M. P. Cardew, *N. H. Porter.

* Has completed the examination.

PAPERS BY GUY'S MEN

Bishop, P. M. F. Sex Hormones in Therapeutics. *Brit. Med. J.*, 1949, i, 165.

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Brewin, T. B. Four Cases of Polypoid Tumour ("Myxoma") within the Left Auricle of the Heart. *Guy's Hosp. Rep.*, 1948, **97**, 64.

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Brock, R. C. Studies in Lung Abscess : vi. Lung Abscess and Bronchial Carcinoma. *Guy's Hosp. Rep.*, 1948, **97**, 75.

Campbell, Maurice. The Blalock-Taussig Operation for Morbus Coeruleus. *Guy's Hosp. Rep.*, 1948, **97**, 1.

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Ryle, J. A. Social Medicine—Some British Pioneers and Public Health Enactments. *Nursing Times*, 1947, **45**, 88.

Ryle, John A. Old Masters and New Methods. *Brit. Med. Students' J.*, 1948, **3**, 4.

——. Nosophobia. *J. Ment. Sc.*, 1948 (Jan.).

——. The modern concept of Social Medicine. *Irish J. Med. Sc.*, 1948 (July).

Siggers, N. Pulpal Anæsthesia. *Brit. Dent. J.*, 1948, **85**, 284.

Simpson, C. K. Dangers of Criminal Instrumental Abortion. *Lancet*, 1949, i, 47.

Slesinger, E. G. Chronic Gastric Ulcer. *Med. Pr.*, 1948, **220**, 557.

Smith, R. E. Quarantine and Surveillance. *Clin. J.*, 1949, **78**, 1.

Southwell, N. Treatment of Hay Fever. *Practitioner*, 1949, **162**, 148.

Stead, G. Place of Physics in the training of the Medical Radiologist. *Brit. J. Radiol.*, 1948, **21**, 373.

Wass, S. H. Osteomyelitis of the Mandible. *Ann. Roy. Coll. Surg.*, 1949, **4**, 48.

Yorke, A. Parapsoriasis en Plaques—Treated with Vitamin D_2. *Proc. Roy. Soc. Med.*, 1948, **41**, 755.

MARRIAGES

GILL—BANNERMAN.—William Gordon Gill to Lilian Salisbury Bannerman, at Guildford, on Saturday, January 29th, 1949.

HAHN—MONAGHAN.—On January 29th, 1949, at Wolfsburg-Kr-Gifhorn, Paul Gerhart Hahn, of Zwickau, Germany, to Ann Mary Monaghan.

DEATHS

HALSTEAD.—On February 1st, 1949, at Bideford, George Ezra, B.A., B.Sc., M.D. Lond., late of Ramsgate, in his 88th year.

REED.—On January 11th, 1949, Thomas Reed, M.R.C.S., L.R.C.P., of 343, London Road, St. Leonards-on-Sea, Sussex.

SPURRELL.—On January 26th, 1949, at Carmarthen, Charles Spurrell, F.R.C.S., aged 82 years.

WYNN-PARRY.—On February 2nd, 1949 (suddenly), Griffith Vaughan Wynn-Parry, M.R.C.S., L.R.C.P., of Camden House, Bletingley, Surrey.

Eds. {H.A.R. R. G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

TO criticise the system of training and qualification in medicine is the prerogative of the unsuccessful examination candidate and also, the cynics say, of the editor short of copy. Yet the subject clearly has a much wider import. Of recent years various august bodies have carried out exhaustive enquiries upon it and published their considered recommendations. One particular aspect might nevertheless be examined again, namely the relationship of the scientific to the clinical studies.

Under the present regime the student embarking upon a medical course finds that for the first three years his attention must be focussed almost exclusively upon scientific and laboratory exercises. As a period for enjoying in the fullest sense the benefits of a university education these years are undoubtedly most valuable. As a means of training the adolescent in the concepts of science and logic they serve a further valuable function. But once this stage is over and the seal is set by the passing of an examination the knowledge so acquired is all too rapidly relegated and forgotten. More dangerous, perhaps, is the frequency with which the student inspired in the first place to a career of medicine for humanitarian reasons finds these little manœuvres with pins and lenses, with chemical formulæ, with plant anatomy and with frog jerks all too irksome and dull so that if he manages to survive these prolonged penances he has little soul left when at last he gets to the bedside.

The practitioner, as Ryle has pointed out, must combine in one person "the attributes of scientist, healer, priest and prophet" and be possessed of a "true and active Natural Philosophy." To this end he should, says Gairdner, "be trained and exercised after the best manner and according to the most thorough discipline of the science of his age; and that he ought to be . . . regarded as being admirable or trustworthy as a healer or physician, chiefly in proportion to the confidence reposed in him as a naturalist, that is a humble, reverent and exact follower and student of Nature."

Man's cerebral capacity is not to be likened to a series of vessels filled as a result of learning, one after another; first those of reading, writing and arithmetic, then those of chemistry, physics, anatomy and physiology and subsequently those of medicine, surgery, obstetrics and so on. Knowledge and, more especially, wisdom come from synthesis and integration.

Practically every clinical student is sooner or later smitten with the remorse that derives from the forgetting of some item of preclinical study that should have a fundamental bearing on his clinical understanding and this, moreover, after labouring for ages in the medical school when he yearned to be in the wards. As the years progress scientific ideas advance ever more the explanations of disease processes and therapeutic responses. But to cram more into the preclinical years, notwithstanding the strong arguments of the specialised teachers, would be fatal. May we plead, instead, for a shortening of the preclinical course, *per se*, and for confining it to general principles. Entry to the wards would then come sooner, with the scope thus provided to study people as individuals in their struggle with illness. Then, as the student developed his faculties of observation so would he seek an explanation of the processes underlying the phenomena before him. Science courses in applied anatomy, physiology, pathology and pharmacology would command an immediate relevance at this stage.

To arrange such a programme might well raise administrative difficulties. There is little doubt, however, that it would bring great advantages.

THE Guy's Hospital Gazette Index to Volume LXII (1948) is ready for distribution and may be obtained free of charge, on application to The Manager, Gazette Office, or The Librarian, Wills Library. Binding Cases 3*s*. 6*d*. each, post 3*d*. extra.

Intervertebral Disc Injury

A REVIEW OF 123 CASES TREATED IN THE ORTHOPÆDIC DEPT.

By V. M. FRANKLIN, F.R.C.S., Orthopædic Registrar, Guy's Hospital.

AN attempt has been made to investigate the results of the treatment of Inter-vertebral Disc Lesions.

300 patients were treated in the Orthopædic Department during 1946 and 1947 and were requested to attend for examination. Of the 123 who responded, 86 were examined and the remaining 37 filled in a questionnaire.

The duration of symptoms before patients were referred to Guy's for treatment averaged 4.2 years. During 1947 this period decreased, as a result, perhaps, of the earlier recognition of Inter-vertebral Disc injury by general practitioners. Males were affected more frequently than females in the proportion of 2 to 1. The age of the patients ranged from 18 to 73 years, the average being 38. The average time since completion of treatment at Guy's was 17.3 months.

Signs and Symptoms.

Of the 123 patients, 78 complained of both backache and sciatica, 15 of sciatica only and 30 of backache only. Wasting of the calf and thigh muscles was present in 11 patients and in 15 the ankle tendon reflex was absent. These signs were usually concomitant: tingling and numbness of the outer side of the leg and foot were complained of by 16 patients, but only in 3 of these could any alteration in sensitivity be demonstrated. Tenderness over the lumbar inter-spinous ligaments was an almost constant finding, even in those who complained of sciatica only. To elicit this sign, complete relaxation of the patient is essential.

Radiological examination usually revealed loss of the lumbar curve and/or narrowing of an Inter-vertebral Disc space. Absence of these signs is of no significance for in many patients with negative X-Ray findings prolapsed Inter-vertebral Disc were found at operation. 3 patients with acute sciatical and radiological evidence of widening of the Inter-vertebral Disc space were found at operation to have a large Disc protrusion. This latter X-Ray appearance may perhaps be due to œdema of the Disc.

The majority of men had been engaged in heavy work necessitating much lifting. It is interesting to note that the majority of the women patients attributed the onset of their symptoms to childbirth and that all these patients had been delivered in the left lateral position. It seems that the hyperflexion of the lumbar spine which this position allows predisposes to Inter-vertebral Disc injury.

Using the golf ball as a simile, 3 types of Disc injury can be described. The small central soft rubber bag can be compared to the nucleus pulposis, and the yards of elastic arranged in layers with fibres running in different directions to the annulus fibrosis.

(1) *Disc Strain.* Here there is a partial tear of the annulus fibrosis. This causes localised backache only, with tenderness over the appropriate inter-spinous ligament. Treatment consists of rest for the back in a plaster of Paris jacket or corset, for 2 to 4 months.

(2) *Disc Bulge.* When the disc strain has been disregarded and the tear of the annulus fibrosis has progressed, the nucleus becomes displaced more posteriorly and produces a bulge into the spinal canal which may press on to a nerve root and cause sciatica. This lesion is also treated by immobilisation in plaster of Paris jacket and corset, but splintage must be maintained for a longer period than in the case of simple strains. After 2–3 months in plaster of Paris, a corset may have to be worn for as long as 1 year.

(3) *Disc Prolapse.* Here the nucleus has actually prolapsed into the spinal canal. This may follow continuous minor strains or a sudden severe strain without previous symptoms. The precipitation of a prolapse may not be entirely dependent on the severity of the strain but may be predisposed to by the pathological condition of the Disc and the age of the patient. The sciatic pain although it may be severe, is sometimes intermittent with intervals of freedom from pain as a result of reduction of the herniated Disc. Any exertion, particularly an unguarded movement, may lead to redislocation. In such cases manipulation or immobilisation may relieve the pain temporarily but removal of the Disc by operation is the only sure cure.

CONSERVATIVE TREATMENT.

Different forms of treatment were employed depending on the severity of the symptoms. A large number of patients had more than one form of treatment. Immobilisation was the most successful.

Physio-Therapy. Of 43 patients treated at Guy's by Physio-Therapy only 8 still remained free of pain when examined for this review.

Manipulation. Of 16 patients treated by manipulation 5 only were free of pain.

Immobilisation. These patients were divided into 2 groups, depending on the severity of the symptoms.

Mild: *The Disc Strain Type.* The majority of these patients complained of backache only, although some had mild sciatica. The 38 patients in this group were provided with surgical corsets. All were symptom free when examined for this review.

Severe: *Disc Bulge and Disc Prolapse Type.* All these patients had severe sciatica pain and were placed in a plaster jacket. The jacket was worn for an average of 10 weeks and was usually followed by a surgical corset. Of a total of 62 patients in this group 18 were completely relieved by a plaster jacket alone, and 44 required further support in a surgical corset. In the cases treated prior to 1946 a long jacket from sternum to pelvis was used and immobilisation was maintained for 3 months. More recently a short jacket has been worn for 8 weeks. The longer jacket, and the use of head traction during its application, did not seem to have any advantage and should be discarded. During the last 2 weeks of the period of immobilisation in plaster it is important for the patient to perform extension exercises to strengthen the spinal muscles.

A small proportion of patients who had been supplied with short lumbo-sacral belts developed pain at a higher level (usually dorsi-lumbar junction) due, no doubt, to strain by fixation of the lower lumbar spine only. A longer

corset which embraces the lower ribs has been adopted. The period for which a corset should be worn varies with the age of the patient and the severity of the condition. If the corset is worn conscientiously, 1 year is usually sufficient.

OPERATIVE TREATMENT.

Of the 123 patients reviewed, only 21 (16 males and 5 females) required operative treatment. All these patients had had a course of conservative treatment first and were not relieved. Of this group 18 patients had a simple laminectomy with removal of the prolapsed disc and 3 had a spinal fusion as well. These 3 patients had marked narrowing of the affected Intervertebral Disc with secondary changes and their chief complaint was persistent backache.

It is interesting to note that in 2 of the patients operated upon a completely prolapsed nucleus was found lying free in the epidural space at some distance below the injured Disc.

RESULTS.

The patients were divided into 4 groups :—

(*a*) Excellent.

(*b*) Good—patients with a slight pain but no disability.

(*c*) Fair—patients with a slight disability but improved by treatment.

(*d*) Poor. Not improved by treatment.

CONSERVATIVE TREATMENT. 102 patients—86% treated by Immobilisation.

41 had excellent results.

42 had good results but complained of a slight pain at times, usually in their back, but had no disability and were back at full work.

12 had fair results. They were improved by treatment but had some remaining disability due in most cases to chronic backache.

7 were not improved.

OPERATIVE TREATMENT. 21 patients.

9 had excellent results. Many of the patients—including a stoker and a brewer's dray man—had returned to heavy work.

9 had good results and were employed, usually in light work.

3 had some disability, usually backache, but were improved.

CONCLUSIONS.

(*a*) Over 80% of the patients in this series were treated by conservative measures of which immobilisation was the most successful.

(*b*) The corset should embrace the lower ribs thus avoiding strain at the dorsi-lumbar junction.

(*c*) A trial of conservative treatment should be given in most cases—*e.g.* plaster of Paris jacket for 2 or 3 weeks and if not relieved, then operative treatment should be considered as it is often difficult to distinguish between a Disc Bulge and a Disc Prolapse.

(*d*) Removal of the Inter-vertebral Disc is highly successful in relieving the root pain, but spinal fusion is required when there is radiological evidence

of narrowing of the Inter-vertebral Disc space and marked secondary osteo-arthritic changes, and the main symptom is backache.

(*e*) In men the chief cause of Disc Injury is work which involves much bending and stooping or heavy lifting, and the injury appears to occur with some unguarded movement.

(*f*) In women, childbirth is the most common cause. It is suggested that the left lateral position during labour which allows hyperflexion of the lumbar spine may be the predisposing factor.

In conclusion, I would like to thank Mr. Stamm and Mr. Batchelor for their encouragement and assistance and the Almoners' Department for their very active co-operation in sending for patients, etc.

Some Lessons of the Exchange, 1948

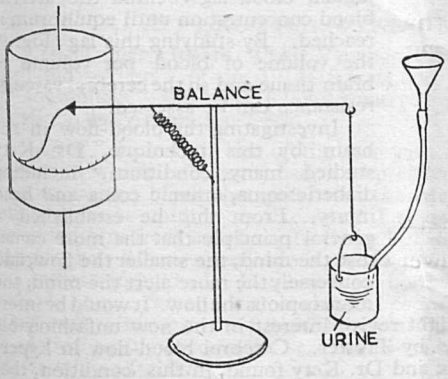
By H. J. B. ATKINS, D.M., M.Ch., F.R.C.S.

(concluded)

6. *Genito-urinary System.* Genito-urinary surgery is practised in the Hopkins in a separate department—the Brady Institute, built by Dr. Hugh Young with money subscribed by that famous American character and *bon viveur*, 'Diamond Jim Brady.' 'Diamond Jim' developed a 'prostate' and the rest was easy. This being so the ordinary visitor is somewhat out of touch with the urological 'goings on,' although the major operations from the Brady Institute are all carried out in the general theatres. Nevertheless, I talked with Dr. William Scott, the director, and he told me of perfusion experiments which he was carrying out on the prostate and of his attempts to find an 'anti-androgen' to correspond with aminopterin, the 'anti-œstrogen.'

In the Hunterian Laboratory experiments are being undertaken to anastomose one ureter to the gall-bladder with subsequent removal of the other kidney, to see whether this organ is a more suitable receptacle for the urine in transplantation of the ureter in ectopia vesicæ and carcinoma of the bladder.

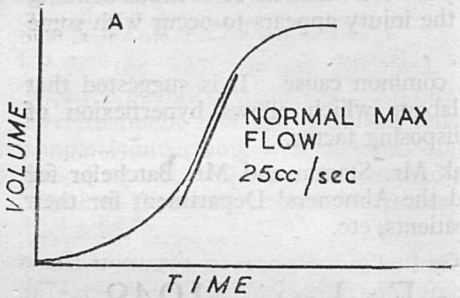
Dr. Lanman told the Halsted Club about his experience with ectopia vesicæ. He implanted the ureters in two stages into the colon and preferred to operate between the second and fifth years. He made a wide communication by slitting the end of the ureter for half an inch before implantation, as he considered that ascending infection following this operation was always indicative of obstruction and never occurred if the junction was free.



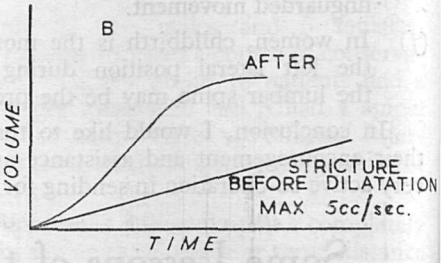
(Fig. 7)

Dr. Drake, an Intern from Philadelphia, had invented an ingenious device for measuring the rate of urinary flow (Fig. 7). This 'uroflometer' (!) enabled him to study the course of a stricture treated by dilation, and gave valuable indication (Fig. 8) of the progress of a case of prostatic obstruction, revealing an otherwise imperceptible deterioration and affording further evidence as to the necessity or otherwise for prostatectomy. Dr. Bazett, formerly of St. Thomas's Hospital, commenting on this instrument, said that no allowance had been made for intravesical pressure and the size of the bladder (*i.e.* the volume of its contents) when the comparisons were made. In order to be of value, comparisons must be made with the bladder filled to the same degree in each case. He felt sure that Dr. Drake could devise some method whereby this could be attained.

Dr. Bazett pointed out that the relation between the pressure inside a hollow spheroidal or cylindrical viscus (P), the tension exerted by its muscular walls (T), and its radius (r) could be expressed by the equation $T=Pr^2$ or $P=T/r^2$. Thus the more



(Fig. 8a)

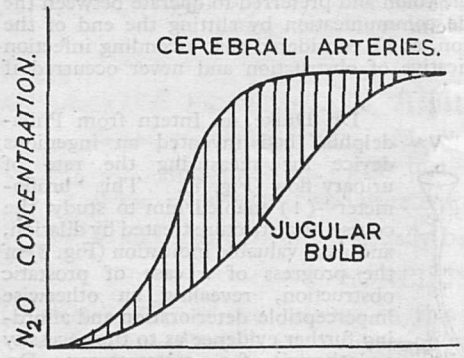


(Fig. 8b)

distended a viscus becomes, the tension required to raise the pressure sufficiently to evacuate it increases by *geometrical* progression. No wonder the bladder musculature is unable to raise the pressure sufficiently to evacuate an over distended bladder !

7. *C.N.S.* The neurological service (and by 'neurological' an American means what we understand by the term 'neurosurgical') is, like the urological service, a more or less detached unit under the control of Dr. Earl Walker who has done much work on the physiology of the thalamus. Apart from operations for hypertension, some of which come under this service, I did not, to my regret, see their work.

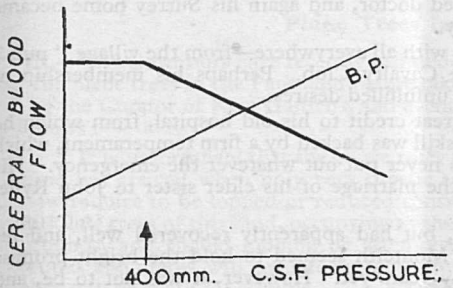
At the Halsted Club meeting, however, some papers of neurological interest were read. One of the most fascinating was that by Dr. Kety, who described his experiments on the work done by the brain and its relation to cerebral vascular resistance and cerebral blood-flow. The technique was based on the principle used by Dr. Bing in his work on the heart, but in these experiments (instead of the coronary sinus) it was the jugular bulb blood which was tapped and compared as to its nitrous oxide content with that of the cerebral arteries. The jugular bulb was entered by a direct puncture with a needle from the surface. As soon as nitrous oxide is inhaled the nitrous oxide content of the cerebral arterial blood begins to rise. There is a latent period before the jugular bulb blood shows any increase in nitrous oxide content, and the concentration of this substance in the jugular blood lags behind the arterial blood concentration until equilibrum is reached. By studying this lag (Fig. 9) the volume of blood per volume of brain tissue and so the cerebral vascular resistance can be assessed.



(Fig. 9)

Investigating the blood-flow in the brain by this technique, Dr. Kety studied many conditions, including diabetic coma, uræmic coma and head injury. From this he established a general principle that the more comatose the mind, the smaller the flow, and conversely the more alert the mind, the more copious the flow. It would be interesting to speculate how far this work might revive interest in the now unfashionable 'sponge theory' of concussion elaborated by Trotter. Cerebral blood-flow in hypertension was also studied by this technique and Dr. Kety found, in this condition, that the flow was diminished and the cerebral vascular resistance increased. By rapidly reducing the hypertension by spinal anæsthesia, however, the cerebral resistance falls, as might be expected, but not to a proportionate degree with the blood-pressure, so that the cerebral flow is still further diminished and cerebral anoxia may result.

By increasing the cerebro-spinal fluid pressure, the cerebral blood-flow could be made to fall, but there was a latent period before this drop occurred due to the fact that the rising blood-pressure (occasioned by the rise in cerebro-spinal fluid pressure) was able to compensate at first for the increased cerebral vascular resistance, and only when the cerebro-spinal fluid pressure reached 400 mm. of water did this compensating mechanism break down and the cerebral blood-flow begin to fall (Fig. 10).



(Fig. 10)

Dr. White read a paper on cordotomy for the relief of pain in paraplegia, and advocated operation in the upper thoracic region. Dr. Grant called attention to the danger of this operation (performed on the contralateral side) when previous attempts had been made to abolish the pain by intrathecal alcohol injection (on the ipsilateral side) since this now bilateral procedure might paralyse the bladder and lead to incontinence.

In such manner the time passed. It was hard to say whether the days were more intellectually stimulating than the evenings were gastronomically so. There has not been time to describe so much else that was discussed—Professor Fontaine's advocacy of sympathectomy for intractable cases of asthma; Dr. Bender's injection of the allantoic veins of chick embryos with tumour cells, and the behaviour of these implants; Dr. Gey's fascinating electron microscopic studies of mitosis in normal and neoplastic cells, how one of these colonies of normal cells in tissue culture suddenly acquired neoplastic characteristics and, when re-injected into rats, produced metastasing lesions; or Dr. Kurt Richter's minutely exact surgery on rats to show how a rat without parathyroids *chooses* to feed out of a test-tube containing a solution rich in calcium, whilst one without adrenals goes by unerring instinct to the solution rich in sodium chloride!

In conclusion I can only say what a stimulus it was to be privileged to work in this great hospital, tuned as is Guy's to a powerful rhythm; to meet surgeons, physicians, physiologists and biochemists all eager to explain and demonstrate their work; to breathe in the spirit of energy and enlightenment which this, the foremost teaching school in America, imparts; and perhaps more particularly to have the opportunity, when the bustle of the day was stilled, to talk quietly of problems of surgery, of research, and of administration with their great presiding genius, to whom all of us at Guy's owe so much—Dr. Blalock.

Obituary

GRIFFITH WYNN VAUGHAN PARRY.

I FIRST met Griffith Wynn Vaughan Parry at Guy's in 1919. Both of us were "old soldiers" of the 1914–18 war, and possibly the fact that we had both been "Gunners" and were fellow-countrymen led to a friendship, which ended with his all too early death last week.

"Griff" had come out of the war with the loss of a leg—through the thigh—a mutilation which I feel sure had a deep effect on his life. At heart he was a country man, interested in all that goes with the country as opposed to the town—shooting, riding, point-to-point races, etc.—and I always felt that his physical handicap, which prevented him from indulging freely and gladly as he would like to have done in these pursuits, was a heavy one indeed, and would have made a weaker man an embittered and morose individual. He, however, bore his trouble well, and never complained. Instead, he overcame it with a cheerful courage, even playing tennis and dancing. It is a tribute to his grit that for so many years down in lonely wind-swept Pembrokeshire he carried on his practice at St. David's—a practice hard to work for an active man, but doubly so for him.

His home at St. David's was *the* centre of hospitality, and many were the evenings in the past when the house rang with "singsongs," for among other things he loved music and social life in all forms, and was the ideal host, aided and abetted by his sister May who kept house for him and supplied the music.

Moving later to Bletchingley, he left a great gap behind him, and many ties of friendship, which were never broken. At Bletchingly again his gifts gave to him a wide and firm circle of friendship. He never put himself out for this purpose, but people were drawn to this imperturbable dry-humoured doctor, and again his Surrey home became a warm and welcome centre of hospitality.

"Griff" had the great gift for mixing with all everywhere—from the village "pub" to the most austere surroundings of the Cavalry Club. Perhaps his membership of the latter was a pointer to his deeper but unfulfilled desires.

He was a good Guy's man and did great credit to his old hospital, from which he qualified in 1924. His high professional skill was backed by a firm temperament, which refused to be flurried or rushed, and was never put out whatever the emergency. His ties with Guy's were made stronger by the marriage of his elder sister to John Ryffel in 1929.

He had started to ail early last year, but had apparently recovered well, and his wedding in May last year to Mrs. Vera Monteith seemed to hold the bright promise of a happy future stretching on for many years yet. However, it was not to be, and the end came with tragic suddenness on Wednesday, February 2nd, bringing to the end, in my case, a friendship of thirty years.

His friends, however, will never forget that straight, handsome, always young looking figure, impeccably dressed, with a slight limp and the walking-stick, as he plodded over the Pembrokeshire fields to his patients, along the Surrey lanes on the same errand, or, in a leisure moment, over the pavement of Piccadilly to the Cavalry Club.

T.G.W.P.

J.R.R. writes :—

Dr. Griffith Wynn Parry succeeded his uncle in the St. David's practice and eminently maintained the family reputation especially in midwifery cases. The practice extended as much as 15 miles in some directions with rough roads—no chauffeur and only one leg to work clutch, brake and throttle and a little distance to get to the car from the house. Functions were comprehensive, including parish doctor and post mortems for the Coroner. In fact the St. David's practice is one of those of which the Ministry of Health will have to take notice. In spite of all this, Parry's reputation was that "he would never let you down." He was adored by his two sisters, my wife and Mrs. Ann, and their loss is almost more than they can bear.

Guy's Diary

FEBRUARY—MARCH

ACADEMIC

Feb. Exhibition. Surgical Dept. "Twenty Questions."

28th. 1.00. Mr. Carter Braine. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. D. W. Beynon. Department of Child Health. Postgraduate Lecture. "Dwarfs." Preclinical Classroom.

Mar.

1st. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.
5.00. Dr. Rawlings. Endocrine Lecture Preclinical Classroom.

2nd. 1.00. Dr. Waterfield. Hæmatological Lecture. Hæmatology Department.

3rd. 12.00. Mr. H. H. Kenshole. Dental Clinical Lecture. "Identification." Dental Theatre.
4.30. X-ray Meeting. Gordon Museum.

4th. 1.00. Dr. Hardwick. Clinical Lecture. "Fever."
2.15. Medical Department. Combined Round. Preclinical Classroom.

7th. 1.00. Mr. Lewis. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. P. R. Evans. Department of Child Health. Postgraduate Lecture. "Umbilical and Inguinal Hernias in Infancy." Preclinical Classroom.

8th. 5.00. Endocrine Lecture. Preclinical Classroom.

9th. 1.00. Dr. Waterfield. Hæmatological Lecture. Hæmatology Department.
4.45. Guy's Science Club. Dr. R. L. Waterfield. "The Measurement of Red-cell Diameters." Staff Common Room. (Tea 4.30.)

10th. 4.30. X-ray Meeting. Gordon Museum.

11th. 2.15. Medical Department. Combined Round. Preclinical Classroom.

12th. 10.00. Mr. Cecil Flemming, University College Hospital. Surgical Departmental Round. Clinical Theatre.

14th. 1.00. Dr. Munro. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. R. C. MacKeith. Department of Child Health. Postgraduate Lecture. "Adolescence." Preclinical Classroom.

SPORT

Mar.

4th. Rifle Club "A" Team *v.* Central Park "A" Team.

5th. Rugby XV. *v.* London Welsh. (H.O.P.).
Hockey 1st XI. *v.* Tonbridge. (H.O.P.).
Hockey 2nd XI. *v.* Tonbridge. (Away).

11th. Rifle Club "A" Team *v.* Harland & Wolff "A" Team.
Rifle Club "B" Team *v.* B.T.H. Willesden "D" Team.

12th. Rugby XV. *v.* Old Paulines. (H.O.P.).

Correspondence

Plane Trees in the Park

SIR,—The Governors have recently had under consideration the desirability of lopping the plane trees in the Park, and before taking any action, decided to seek the advice of the Curator of Kew Gardens, and eventually received from him a detailed report as follows :—

"It is unfortunate that the above trees are planted so closely, because to-day the time has arrived when only very drastic action will meet the position. The trees now require to be lopped or reduced considerably in number. It is a great pity to mutilate trees of this kind, occupying as they do a very important site in the Hospital grounds, and should lopping be attempted there is no doubt that the amputated trunks and stems will remain unsightly for many years. To the ardent tree-lover they will be spoilt for all time.

The obvious method of treatment is to thin out the number of trees, and this is made fairly simple by the fact that the better trees are well spaced apart. From the south end of the row, examination shows each tree to be as follows :—

No. 1. The finest tree of all in the grounds. Well balanced in every way, and its only drawback the fact that it is very closely planted to the buildings. A little thinning of the branches closest to the buildings should enable the tree to remain perfectly safe for a good number of years.

No. 2. This tree leans badly over the lawn and is also mis-shaped in that it is forked low down. It is recommended that this tree be removed and so ensure adequate light being available for the trees on either side of it.

No. 3. This is quite a good tree which requires one or two lower branches reduced in a south-westerly direction. It will benefit considerably from the removal of tree No. 2 and again should be quite healthy for a good number of years.

No. 4. } These two trees will never make really good specimens. They were planted
No. 5. } too closely and have suffered considerably from being drawn upwards in their early days. They could both very well be removed and allow more growing space for their fellows.

No. 6. A tree which could have been quite a good specimen if it had had ample room for development. There is a tendency to grow towards the north, but should trees 4 and 5 be removed, then within five or ten years there will be a definite tendency for growth towards the south side, resulting in a better balanced specimen.

No. 7. This is not nearly such a good tree as Nos. 6 or 8, and as it will be an advantage to leave the latter specimen growing, there is no doubt but that it would be wise to remove this tree.

No. 8. This, like tree No. 1, has benefited from being the end tree, and though it is forked rather low down it is quite safe and appears to be an exceptionally healthy tree. It will be well to leave the tree standing, though a little judicious thinning of the upper branch system will give added strength and result in additional light penetrating to the buildings in the vicinity.

Summarising the above remarks, it will be seen that four trees are recommended to be left, these being Nos. 1, 3, 6 and 8, respectively, and four, Nos. 2, 4, 5 and 7 removed. If this recommendation is approved, the opportunity should be taken of planting about three groups of small flowering trees."

After careful consideration, the Governors have decided to accept the advice of the Curator of Kew Gardens and to have the work which he recommends carried out. As you know, the War Memorial Fund, amounting now to approximately £2,000, is to be spent on laying out the Hospital grounds with beds of flowers, etc. As soon as the work on the trees has been carried out, the lay-out of the Park will be planned and put into effect.

Yours, etc.,

W. D. DOHERTY,

Superintendent.

Superintendent's Office,

The B.M.S.A.

SIR,—May I draw your attention to the announcement of a referendum relating to Guy's affiliation to the B.M.S.A., which has appeared on the wall board in the Medical School. This proclamation, made anonymously and with no apparent authority, asserts that not only is a referendum necessary but also that a vote against affiliation is ludicrous. It contains such phrases as : " The need for a National Body of Medical Students is self evident," " Inter-Hospital Conferences and discussions *can only* be carried out by some Inter-Hospital organisation," and " Matters concerning the welfare of the students of the Country *must* be dealt with by an Inter-Hospital organisation." (The italics are mine).

Such dictatorial and unwarranted statements require contradiction.

I attended one of the B.M.S.A. meetings in 1943 and the general consensus of opinion of Guy's men there, at that time, was that the B.M.S.A. not only lacked worthwhile ideals and a constructive policy but also that in some respects it was a potentially dangerous body. A decision not to affiliate was made then and has proved the decision of subsequent generations of students. The fact that so many men in Guy's have refrained from taking an interest in the B.M.S.A., as shown by the number of abstentions at previous votings, reveals that, here at any rate, there is no urgent desire for a National body of medical students. That other hospitals share that opinion is shown by the fact that out of fifteen teaching hospitals in the London Area only seven have bodies affiliated to the B.M.S.A. The fact that St. Thomas's, Bart's and the Middlesex are among the abstainers deals effectively with any charge of petty isolation and non-cooperation that may be levelled against Guy's.

The lack of an Inter-Hospital Organisation has never prevented the secretaries of the sports clubs arranging fixtures with other hospitals and what is true of these activities is true also of conferences and discussions.

That " Matters concerning the welfare of students of the Country must be dealt with by an Inter-Hospital Organisation " is no more self-evident than the two above-mentioned assertions, for the likelihood of such matters arising is small. A man does not have to be a medical student, he enters a hospital voluntarily and is not an employed man whose welfare needs safeguarding by National Bodies. The relationship between him and his Medical School, in a sense his employer, is a matter for private and not national arrangement. If he feels that in some way he has not got his rights, or that his personal status and dignity is being affronted he can always make way for less sensitive men.

The writers of the announcement claim that the present situation is ludicrous and that it can only be put right by instant affiliation, the possibility of " contracting out " not having occurred to them, so that we are bidden to vote for affiliation and so save the faces of those, who against the majority wish of the medical students here, have joined the B.M.S.A.

One is left with the feeling that, if this time a majority vote in favour of affiliation is not forthcoming, a further referendum will be announced within a short time.

Unlike the author(s) of the announcement I am not reluctant to put my name to my opinions.

Yours, etc.,

RAY L. LUFFINGHAM.

Guy's Hospital,
London, S.E.1.

Jacobson

SIR,—Jacobson formed a link between the wonderful old Church of Ewelme in Oxfordshire, and Guy's.

He was born there. His father who afterwards became Bishop of Chester, went there as Rector in 1848, a hundred years ago. Jacobson himself lies in a nameless grave in the Churchyard of Ewhurst, in Kent.

Ewelme Church is notable for the tomb of Chaucer's son and of his daughter, who became Duchess of Suffolk, and it is well worth a special journey to see them. Had the Tudors been defeated at the Battle of Bosworth Field, her son would have become King of England. Henry VIII spent one of his honeymoons in the village, which has a most distinguished history.

Knowing the affectionate regard in which the memory of Jacobson is held, it occurred to me that among such of his old House Surgeons and Dressers as may still be alive, there might be some who would like to send a small contribution towards the repair of the roof of the church, which is in a bad way, as a tribute to his memory.

They should be addressed to :—

Mrs. M. G. Somervell,
The Old Rectory,
Ewelme, Oxon.

Yours, etc.,

Brookwood,
Surrey.

EL HAKIM PASHA.

Guy's Hospital Out-Patient Department

The Appointments System in Out-patients is designed to present an agreed number of cases per hour or per half-hour, depending on the nature of the Clinic, to the Physician or Surgeon in charge. The time at which the patient is asked to come to the Hospital is an attendance time and not an actual appointment to see the Consultant. In many Clinics the case histories of patients are taken by Ward Clerks before they see the Physician or Surgeon in charge, which causes some delay, but on the whole, the system works well and the time spent by patients waiting in the Out-patient Department is steadily diminishing. Doctors may write to the Out-patient Department or telephone HOP 3500, Extension 11 or 13, and make appointments for their patients, or patients may make appointments direct, provided that they have already been seen by their general practitioners, who must have given them a letter of recommendation. Patients cannot be seen in the Out-patient Clinics except by appointment.

An Admitting Officer, Dr. A. Angus, was appointed in January, 1948, to see that the available beds were used to the best advantage and to simplify the admission of emergency cases from doctors and the Emergency Bed Service. All Hospital calls (HOP 3500) are put through to Dr. Angus between the hours of 9 a.m. and 5 p.m., and it is his endeavour to give an immediate answer as to whether there is a bed available or not. After 5 p.m., these calls are put through to the Take-in House Officer in the College (HOP 3500, Extension 29). Unfortunately, the internal communication system throughout the Hospital is out of date, and we are in the process of installing a completely new internal automatic telephone system and a flashing light calling system, which it is hoped will improve communications.

MONDAY—	Morning ..	Medical	Dr. Baker
		Surgical	Sir Heneage Ogilvie
		Skins	Dr. Forman
		Children	Dr. MacKeith
	Afternoon ..	Surgical	Mr. Blackburn
		Fractures	Mr. Batchelor
		Ear, Nose and Throat	Mr. Cann
		Medical	Dr. Kauntze
		Skins	Dr. Barber and Dr. Forman
		Eyes	Mr. Law
		Varicose Veins	Mr. Glover
5.30 p.m.—	Reference Clinic..	Diseases of Lung (Refills only)	Dr. Boland
TUESDAY—	Morning ..	Medical	Dr. Grant
		Surgical	Mr. Massie
		Eyes	Mr. Morgan
		Neurological	Sir Charles Symonds
		Psychiatric	Dr. Munro
		Gynæcological	Mr. Cook
	Reference Clinic..	Hæmatological	Dr. Waterfield
	Afternoon ..	Genito-Urinary	Mr. Kilpatrick
		Endocrine	Dr. Bishop
		Diabetic Clinic	Dr. Hardwick
		Ear, Nose and Throat	Mr. Reading
		Asthma	Dr. Kauntze
	Reference Clinic..	Radiotherapy	Mr. Carter-Braine (Dr. Wayte)
		Psychological	Clinical Assistant

WEDNESDAY—Morning	Medical		Sir John Conybeare
	Asthma		Dr. Kauntze
	Surgical		Mr. Wass
	Skins		Dr. Forman
	Children		Dr. Evans
	Gynæcological		Mr. Blaikley or Mr. Lewis (alternate weeks)
Afternoon	Hearing Aid Clinic		Mr. Cann or Mr. Reading (alternate weeks)
	Dental (Ante-Natal only)		
	Surgical		Mr. Atkins
	Fractures		Mr. Massie
Reference Clinic	Vaccine		Dr. Knott
	Skins		Dr. Barber and Dr. Forman
	Orthopædics		Mr. Stamm
THURSDAY— Morning	Medical		Dr. Hardwick
	Surgical		Mr. Eckhoff
	Ear, Nose and Throat		Mr. Cann
	Skins		Dr. Forman
	Neurological		Dr. McArdle
Reference Clinic	Defective Speech		Mr. Willmore
Afternoon	Eyes		Mr. Law
	Diseases of the Lung		Dr. Boland
	Gynæcological		Mr. Gibberd
	Cardiac Clinic		Dr. Campbell
	Surgical (Thyroid)		Mr. Slesinger
3.30 p.m.	Mastitis Clinic		Mr. Atkins
4.30 p.m.	Diabetic Clinic		Dr. Hardwick
4.30 p.m.	Sigmoidoscopy Session		Mr. Wass
FRIDAY— Morning	Thoracic		Mr. Brock
	Ear, Nose and Throat		Mr. Reading
	Medical		Dr. Mann
	Gynæcological		Mr. McNair
	Neurological		Sir Charles Symonds
	Children		Dr. MacKeith
	Psychiatric		Dr. Munro
Afternoon	Genito-Urinary		Mr. Doherty
	Fractures		Mr. Stamm
	Orthopædics		Mr. Batchelor
	Eyes		Mr. Morgan
	Medical		Dr. Baker
SATURDAY— Morning	Medical		Dr. Kauntze
	Surgical		Mr. Lawrie
Reference Clinic	Defective Speech		Mr. Willmore

DAILY—

Chiropody: Monday and Tuesday afternoon; Wednesday and Friday morning
Dental: Morning and Afternoon
Back Surgery: Morning
O.P.O.: Monday and Tuesday morning; Wednesday all day; Thursday and Friday afternoon

Sport

CLUBS' UNION

COMPULSORY MEMBERSHIP

At the General Meeting of the Clubs' Union, held on 10th February, 1949, it was agreed that the subscription should be raised to £5 5s. 0d. per annum. On the question of compulsory membership no decision was reached. The idea of conducting a referendum among the student body on this subject was suggested. When the Clubs' Union Council met on 11th February, the raised rate of subscription was finally ratified, and it was agreed that a referendum about compulsory membership should be held forthwith.

Voting papers are being issued to every student of the Medical and Dental Schools. Space is provided to record :—

(i) Support for or against compulsory membership.

(ii) Whether such a change should be permanent or for a trial period of five years in the first instance.

***Completed papers should be deposited in* the appropriate ballot boxes to be found in the entrance halls of the Medical and Dental Schools not later than SATURDAY, 5th MARCH.**

The purpose of the signature on each form is to check any possible duplication. Counting of the votes will be absolutely confidential.

G. S. CHANNELL,
Honorary Secretary.

RUGBY

GUY'S *v.* ABERAVON

at H.O.P. Won 14—6.
19th February, 1949.

It is doubtful whether the Ministry of Transport approve of the Guy's–Aberavon fixture, so numerous were the Welsh supporters for this match. For the past three seasons the weather has been extremely unkind so it was a great pleasure to find spring sunshine gracing H.O.P. Guy's, at full strength with both Brunow and Keller playing

despite the proximity of the cup match, began in leisurely manner. Indeed, for the first half, one wondered whether the visiting supporters considered their money well spent. Guy's forwards were being outplayed in the tight scrums and it was rare for the backs to be set in motion. In the line-outs, however, Guy's were more than holding their own, thanks mainly to sterling work by Gwynn Davies. It was, however, not until mid-way through the second half that Guy's, now 3 points down, livened up at all: heeling quickly from a tight scrum Brunow, standing well back, dropped a goal. This was followed by a clever change in direction by D. Le Clus from a pass from Williams. Then several forwards handled before Williams himself touched down. D. Le Clus converted. Guy's, now with the bit between their teeth, were unstoppable and further tries were scored by M. Gray and Keller after one of his bulldozing runs straight from the kick-off. Aberavon were not dismayed, for they had more than held their own up to fifteen minutes from time, when the strain of the journey began to tell. From the sounds of rejoicing they soon recovered their spirits, and passed a pleasant evening in song.

INTER-HOSPITALS CUP
GUY'S *v.* CHARING CROSS

at Richmond. Won 36—3.
22nd February, 1949.

Flashes of brilliance are not going to be sufficient to carry Guy's through the Hospital Cup matches. This was well shown on Tuesday. Although they scored eight tries, two fairly early giving them an eight point lead, they were completely rattled by hard fighting and rush tactics of the Charing Cross pack and for the whole of the first half Guy's were hardly ever on the attack. Later in the game, however, nothing could prevent the Guy's backs scoring for there was almost no defence in the Charing Cross back line. Gray, Heber (2), D. Le Clus, Davies, Malyon, Rademan and Williams all scored for Guy's. It was good to see Tom Lewis back again in the Guy's side and playing remarkably well after so little training.

The Cup now lies in exactly the same position as last year. Mary's play London in the first Semi-final on Tuesday, 1st March, and Guy's play Middlesex—a tough game—on the 3rd March, both at Richmond Athletic Ground.

Nothing rallies the team so much as good supporters and it is to be hoped that as many people as possible will be there next Thursday to shout the team to victory.

ASSOCIATION FOOTBALL

GUY'S *v.* OLD LATYMERIANS

at Hounslow. Won 2—1.
12th February, 1949.

Guy's visited the club who befriended us by sponsoring our entry into the S.A.L., and were unfriendly enough to return home with two points.

The Old Boys, helped by playing with the wind and bright sun behind them in the first half, had most of the play; and it speaks highly of the Guy's defence that they kept the score to 0—0 at half-time.

Guy's went ahead early in the second half when in a goalmouth melée following one of several well taken corner kicks by Skaith, Whitaker headed in. Old Latymerians retaliated, and scored when an alarming miskick presented their right winger with an open goal. Play was now very even with both forward lines well held by good defences, until five minutes from time when the Old Boys' goal-keeper harassed by Lewis only managed to push a centre from the left to the feet of the oncoming Sturdy who made no mistake with a hard drive.

Fearn, Lipington and Young all gave their customary fine performances, and Swift worked tremendously hard in giving his forwards plenty of the ball.

HOCKEY

GUY'S *v.* ADMIRALTY WIRELESS SECTION

at H.O.P. Won 6—0.
Wednesday, 9th February, 1949.

Guy's fielded a combined team of whom six were players drawn from the 2nd and 3rd XI's. But their visitors were no match for them and the game was one of the most one-sided seen this season.

The half-backs assisted by G. Danford, who played a forceful game as an attacking full-back, fed the forwards well, so that they were able to press home the attack for long spells. Had the shooting been more accurate, the tally might well have been doubled. Goals were scored by D. Blake (3), R. Hodson (2) and H. Meyer (1).

GUY'S *v.* INLAND REVENUE

at H.O.P. Won 6—0.
Saturday, 12th February, 1949.

Although Guy's were the better side in every department of the game, they had the advantage of youth and speed and these were well exploited here. A weak half-back line gave the Inland Revenue forwards few chances and the Hospital defence was frequently able to pass to the attack. A feature of the game was the fine combination and supporting play of the Guy's half-back line. The forwards had an enjoyable day, with some good movements which brought three goals in each half. The scorers were C. Opie (4), R. Hodson (1), and H. Meyer (1).

2nd ROUND INTER-HOSPITALS CUP
GUY'S *v.* WESTMINSTER HOSPITAL

at H.O.P. Won 2—0.
16th February, 1949.

Whether it is that Cup matches are more exacting or whether Guy's were feeling the strain of having played six games in three weeks, the team gave one of the poorest displays of the season. The defence was slow and sometimes confused, and the forwards, besides lacking cohesion, failed to make use of the opportunities offered.

Westminster played a much harder game in the first half and might have scored had their forwards been more forceful. They pressed hard from the start and, after Guy's had been penalised several times outside the circle, forced a penalty corner from which the centre-forward shot wide. The Hospital rallied for a time, but passes were muffled and Westminster were soon back again for two more corners. They were unlucky not to score when a rising shot hit the post. Guy's now began to settle down, the forwards were moving better and, after some pressure, they were rewarded with three corners. C. Opie scored from the last of these with a drive which the goalkeeper misjudged.

Guy's had more of the play in the second half and, but for some unusually strict refereeing, might well have increased their lead earlier. As it was, two promising moves were given "offside" at a critical moment, as was a goal by S. Earl. The second goal was scored by R. Hodson who drove hard from the top of the circle.

GUY'S *v.* UNITED SERVICES, PORTSMOUTH

at H.O.P. Lost 1—0.
19th February, 1949.

The 1st XI. were beaten for the first time this season in an enjoyable game, full of good hitting and fast movements. The teams were evenly matched, Guy's had recovered some of their old form, and a reversed score would have been as fair a result. Although the Services' forwards

had fewer chances in the circle, they made better use of them, R. Sonnenfeld playing a good game in goal for the Hospital.

Guy's went to the attack straight away, and the U.S. defence fought hard to clear. Play swung the other way and then back again when the defence recovered well. Then a good pass from the left gave S. Earl the chance of a fine solo run but his shot just missed the post.

Fortunes swayed first one way and then the other in the second half. The U.S. forwards were swinging the ball about more but were foiled time and again by a quickly-covering defence. Then, with ten minutes to go, their centre-forward scored with a bouncing shot from the top of the circle. Guy's tried hard for the equaliser and repeatedly stormed the visitors' goal. But a penalty corner was of no avail and a hard-working U.S. defence retrieved many a desperate situation in the circle. At the final whistle, Guy's cheered heartily for their sporting visitors, confident too, that they had themselves done well.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

*Applications are invited for the appointment of **Assistant Physician to the Dermatological Department** of Guy's Hospital (part-time), with attendance on two sessions per week with remuneration at the rate of £200 per annum per session, subject to revision when the new Ministry of Health scales of salaries are published. The appointment is of Consultant status, and applicants are required to hold a higher qualification. Applications, together with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, not later than 28th February, 1949.

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*In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of members of the Board of Advisory Appointments Committee will lead to disqualification.

Applications are invited for the appointment of **Lecturer in Chemical Pathology.** Salary £650 rising to £800 per annum, with superannuation and family allowance. A medical qualification is desirable but not essential. Date of commencement of the appointment to be arranged.

Application, giving the names of three referees, should be made on a form to be obtained from the Dean of the Medical School, not later than 8th March, 1949.

THE RESIDENTS' BALL

The Residents' Ball is being held this year on May 20th at the Park Lane Hotel.

The reception will be at 7.30 p.m. and Dinner will be served after this. There will be a buffet later in the evening.

Dancing to Tommy de Roco's band will continue until 2 a.m.

Double tickets at Three Guineas each may be obtained from the Residents.

THIRTY CLUB DINNER, 1949

The Thirty Club Dinner will be held on Friday, May 13th at the Trocadero Restaurant. It is hoped that this preliminary notice will enable members to keep the date reserved. Members will receive full details at a later date.

WAR MEMORIAL APPEAL

DONATIONS RECEIVED UP TO 31st JANUARY, 1949

Total at 31st December, 1948 .. £1,625 2 8
£15.—Mackenzie, R. R. £5 5s.—Knott, F. A. £5.—Gration, Miss H. M. £2 2s.—Denton, P. H.; Hamma, Miss J.; Koonvisal, T.; Read, Mrs. L. B.; Rosen, M. C. £2.—Mason, Miss E. £1 1s.—Barkley, Miss A.; Bush, R. A.; Carr. T. E. Ashdown; D'Albon, Miss M. Y.; Forrest, W. I. N.; Gale, Miss D.; Howes, Miss J. H.; James, Miss J. M.; Kustow, B.; Mallandaine, L. A.; Marriott, Miss M. J.; Robins, Miss A. C.; Ryan, Miss M.; Steeds, Mrs. J. M. £1.—Maltby, Mrs. C. L.; Mutimer, Miss E. L.; Phillips, Miss A. M.; Plomer, E. N.; Risdon, Miss E. J.; Underwood, M. 10s. 6d.—Gill, Mrs. K. E.; Hopkins, Miss F. 10s.—Carr-Hill, Miss E. M.; Corder, Miss G.; Fricker, Miss A.; Hemming, Miss F. P.; Lendrum, Miss A.; Mannell, Miss L. G.; Oldfield, Miss M. M.; Stewart, Mrs. W.; Wilks, Mrs. E. V. 5s.—Andrews, Miss A. P.; De Laveleye, Miss M. E.; Fletcher, Miss A. M.; Muir, Mrs. M.; Hewitt, Miss M. L.; Rigby, Miss A.; Stokes, Miss D. G.; Thackray, Miss G. M.

Total .. £1,691 2 8

CHANGES OF ADDRESS

H. E. Edney, L.D.S., R.C.S., The Hollies, Main Street, Brampton, Cumberland. (Tel.: Brampton 231.)

W. G. Gill, M.Ch., Firs Cottage, The Avenue, Godalming, Tel. 162 (Residence), and Telford Lodge, Lower Edgeborough Road, Guildford, Tel. 4989 (Consulting Room).

A. G. Ord, F.R.C.S., Saxilby, New Brighton Road, Emsworth, Hants. (Tel.: Emsworth 222.)

W. R. Russell, M.R.C.S., D.R.C.O.G., Northcote House, Blackwater, Camberley, Surrey. (Tel.: Camberley 513.)

John D. Trethowan, M.B., B.Ch., 27, Sandon Avenue, The Westlands, Newcastle-under-Lyme. (Tel.: Newcastle, Staffs 65104.)

BIRTHS

DALTON.—On February 5th, 1949, in the County Maternity Home, Aberystwyth, to Kathleen (née Hipkiss), wife of Patrick Dalton—a daughter (Annette).

DOWN.—On February 6th, 1949, at Kensington, to Nora, wife of George R. Down, L.D.S., R.C.S.—a son (George Charles).

HARVEY.—On February 18th, 1949, in the Maidenhead Nursing Home, to Kathleen (née Wood), wife of P. D. Harvey—a son (Andrew).

HOUSTON.—On February 12th, 1949, in Nuffield House, Guy's Hospital, to Dr. Thelma C. Houston, wife of Dr. J. C. Houston—a son.

DEATHS

PAXON.—On February 17th, 1949, at 30, St. George's Road, N.13, George Ernest Paxon, M.R.C.S., L.R.C.P., L.D.S., the second son of Mr. and Mrs. George H. Paxon.

ROGERSON.—On February 10th, 1949, Cuthbert Harry Rogerson, M.D., F.R.C.P., at Baltimore, U.S.A., aged 37 years.

Eds. {H.A.R. R. G.

GUY'S HOSPITAL GAZETTE

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PASSIM

IN th's changing world one needs to be something of a sentimentalist to appreciate the little of tradition which remains unchanged. The topper and the tails have gone for ever, and with them some of the pomp and even some of the grace of the early years of this century. This is an age of utility, and what was the use of topper or tails or even pomp or grace? What was the use of that or that or that . . . and so one might go on. What was the use? Traditions are whittled down until the whole world soon will conform to the tastes of this era in which the conservation of time, or the accumulation of money, or the preservation of energy and the demonstration of utility are the hall-mark of all worth. Ask us to submit to analysis the reasons for our feelings of joyful expectation, and we should fail to satisfy your standards. But that won't make us in any way want to, or be willing to, deny that our feelings are ones of joyful expectation. *The Residents' Play will take place again this year.* Each spring sees time more precious to the Residents than the spring before, the hustle and the bustle more intense, energy more valuable, expense more difficult to keep down, and all more difficult to justify. But the Residents, God-bless'em, have justified it to themselves, and so for yet another year there will be a week (this time early in May) in which the whole Hospital will hum with the gossip of their theatricals—unjustifiable may be, but incomparable as a part of the Guy's tradition, July the fifth or no July the fifth. Who *could* deny feelings of joyful expectation, even if they were a little flavoured with apprehension? At least the tradition will not die out in 1949.

H. M. M. Woodward, one time president of the O.U.D.S., entered the wards as a student in January, 1900 (he was taking part at the time in a play at the Garrick Theatre). The following year, when invited to perform at one of the " smokers " then held from time to time by the Residents, he met Harold Wacher, who had been a member of the Footlights Club at Cambridge. Between them they conceived the idea of giving a show at Christmas; the Residents were enthusiastic, and that December, " A Dramatic Entertainment " took place in the Governors' Court-room. Herbert Eason conducted the Orchestra. The Residents Play was born, and such was the enthusiasm of its reception that it became an annual event, unbroken until 1916.

In that pre-first-war period, amongst the authors, one finds names like H. C. Cameron, Harold Chapple, H. W. Barber, E. G. Slesinger, G. Marshall, and T. I. Bennett; amongst the producers, Woodward, Edridge, Brookhouse, Chapple, Tanner.

After the first World War, they recommenced in 1922, E. D. Grasby, E. R. Boland, P. V. Reading, P. M. F. Bishop, C. G. Baker, and S. H. Wass were all numbered amongst the authors of this period, while Ive and de Gruchy wrote most of the music. In 1939, the last play before the recent war, W. N. Mann wrote the lyrics, T. H. Hills the music.

What a galaxy of Guy's names are there! What wicked plots, what lilting music, what burlesque! Was there any wonder that when the war was over we hoped that the Residents' Play which had started in 1901 as a Christmas occasion in the Court Room, moved to the Physiology Theatre in 1906, and became an occasion for early Spring in 1922, would somehow, somewhere, sometime come back? Was there any wonder that its revival in 1947 was greeted with universal approval? Is there any wonder that the news of a " Residents' Play—1949 " gives rise to feelings of joyful expectation? No, none! None at all!

A MEMORIAL service to the late Sir William Hale White, K.B.E., M.D., will be held at St. Peter's Church, Vere Street, W.1, on Wednesday, March 16th, at 12.15 p.m. An address will be given by Sir Henry Dale, O.M., G.B.E. We hope to publish an obituary notice in a future issue of *The Gazette*.

Pleasure at the Helm

or MOTHER AND CHILD RECONSIDERED.

A Lecture given in the Department of Child Health by H. St. H. VERTUE, M.A., D.M.

Vivere Naturæ sic convenienter oportet.
Hor.

GENTLEMEN, it is more than two years since I have addressed an audience of Guy's men and I am very glad to do so again. I have been reading the life of Francis Thompson and more than once I have thought that if only he had not gone to Manchester but mingled with the cheerful men of Guy's, he might have taken some interest in what was going on about him instead of taking opium, as he did. When I came here I was welcomed by an extremely courteous person, no less than Dr. Cameron, who founded this department and was then Dean. There was no selection committee in those days: one simply came, and it was the scientific physicians here that drew one. I am devoted to Science, but I do maintain that Science is not the all-in-all of Medicine. Let us take the case of Mother and Child and examine them from a more philosophical standpoint, and we shall see that Science has not told us all about them that is helpful but has indeed sometimes actually misled us. Let us then avail ourselves of the privilege of cultured men, who are not bound to the period in which they happen to live but can move freely through time, and adopt the standpoint that best suits the occasion. I propose that we assume the Epicurean because Epicurus lived in times that in many ways resembled our own, attained to most of those important achievements of our age which would give him a similar view of the world in which we live, and avoided most of our worst mistakes. It is not a perfect philosophy, but it is much better than anything which has come out of our own times.

Lucretius opened his great poem on the Epicurean system with an invocation to Venus, which is one of the masterpieces of Latin poetry—indeed of any poetry known to me. I will not quote it but invite you to attain the right frame of mind by contemplating pictures of the Goddess of Love from the hands of artists, masters of their craft. Here they are, in one of Mr. Faber's useful volumes, frankly French, formally Florentine, delightfully Dutch, and typically Titianesque.

The sage thought that living things move towards a goal which he called ἡδονή (L. *voluptas*.) There is no English equivalent, but if we use our word pleasure in the sense of that which pleases and divest it of its common gross associations—so fulsome pleasure clog him and drown his heart in the gross mud-honey of town—then "pleasure" will do. That from which living things move away is ἄλγος, pain. These conceptions, as you may plainly see, are quite in harmony with modern physiology. There is a motive force that drives them away from pain and on towards pleasure and that is ἐπιθυμία, desire. Desires are of three kinds. The first are φυσικαὶ καὶ ἀναγκαῖαι, that is natural and necessary, and these need to be satisfied. Such desires are hunger and thirst, the desire for warmth, shelter and clothing, and for ἀοχλησία, comfort of body, and εὐδαιμονία, well-being of mind. The second class are natural but not necessary, for instance sex, which may be gratified or not as prudence dictates; and the third, neither natural nor necessary, are called

κεναί, "vain"; they are due to such things as luxury, extravagance or pride, which a wise man suppresses. To choose the right pleasure and to attain to it by the right means the Epicurean relies on the faculty called φρόνησις, that is practical wisdom or prudence.

"Phronesis his sweet sister, of all those
His friends the dearest,"

he might say, parodying Keats. These conceptions, simply expounded, form the basis of the happy life, and in the stifling complexity of modern days there is still to be found a glimpse of their application in successful motherhood.

Behold then the infant lying on his mother's lap with no eyes for anything in all the world but her! The modern mother is nothing if not good-natured, and she can and usually does supply all that the infant wants that is also necessary for him. He generally represents the form of pleasure that Epicurus thought was best, the ἡδονὴ καταστηματική, or static pleasure, result of a chemical equilibrium in the ψυχή, or organ of sensation. Knowing nothing of the central nervous system the philosopher made what use he could of current beliefs in a ψυχή, *anima* or breath. Briefly said, he supposed that it was a tenuous gas diffused through the frame and held in loose chemical combination with air by a kind of co-ordinate linkage. The pain of want, τὸ κατ' ἔνδειαν ἀλγοῦν, was a result of molecular disturbance; the satisfaction of want resulted in molecular re-arrangement and gave rise in the process to one form of pleasure, the ἡδονὴ κινητική. But the height of pleasure was not reached until chemical equilibrium was complete. Then came the ἡδουὴ καταστηματική, or static pleasure. That our sensations of pain and pleasure depend on chemico-physical changes seems likely enough, though to-day we assign them to the nervous system and not to a gas diffused through the tissues.

Such a perfect picture is the infant of this static pleasure often enough that every sympathetic beholder experiences a like sensation in himself. But chemical equilibrium is a final phase: it can be disturbed, but it cannot receive addition. There must therefore be a limit to pleasure and it is a common mistake not to understand this. To keep offering a baby food, for instance, in the hope of pleasing it the more is to contravene Epicurean principles. To add that extra scoop of dried milk to each feed in the hope of obtaining an extra contentment serves not to do him good but to make him fat. Such an aldermanic child as this is not a seemly sight, though fortunately no permanent harm is done, for the modern dried milks sit easy on the stomach and are virtually proof against folly. To rear a child on native cows' milk requires more skill and care. It cannot usually be given in excess without provoking an upset, and for this reason, if for no other, in the hands of a competent woman who can be trusted with it, it will produce the more beautiful and athletic child.

Gross mistakes in feeding are now a thing of the past, but there is still a foe in the field, a more subtle one, and that is dogma. For example, a woman is told that she must feed her child every four hours, she is given that injunction as though it were an irrefutable revelation of the truth and she accepts it as if it were something out of the Twelve Tables. Many children—most children—are complacent about being fed every four hours, but not all. Some like to take small feeds at short intervals and will not thrive if kept too long away from the breast; others prefer heavy meals and long sleeps. In all

cases prudence, φρόνησις, must be the guide, not dogma. Four hourly feeding is a method that suits most mothers and children, but it is not a rule : it is one means to an end, and that end is the ἡδονὴ καταστηματική, or static pleasure. When a woman came to me recently because her infant *would* take short feeds frequently, she was advised to leave well alone. It was a small girl-baby, amiable, playful and daintily fashioned, yet because it did not suck at the prescribed times nor attain to the prescribed weight (another dogma !), it seemed to the mother's mind that there must be a fault, which could only lie in her secretion of milk. So a test-feed was arranged and a large secretion of seven ounces was revealed. Determined now on doing the right thing she insisted on feeding her baby four hourly, upset its digestion and had the mortification of seeing a loss of weight for the first time. Here is an explanation why in the past the best mothers did not always obtain the best results. We did not fix our eyes on the " summum bonum quo tendimus omnes," we trusted in dogma, the mothers obeyed and the children suffered. Meantime some easy-going, good natured creature would surpass her more intelligent and conscientious sister. Even the pursuit of virtue can be pressed too far in the eyes of the Epicurean. Has not Horace warned us ?

> Insani sapiens nomen ferat, aequus iniqui,
> ultra quam satis est Virtutem si petat ipsum.
>
> He earns the name of fool, though just and wise,
> Who seeks more virtue than his need supplies.

As a matter of fact a little adroit questioning shows that the majority of mothers do not keep strictly to a four hourly routine. The reputed interval of four hours is only an average or an approximation. What brings success is regularity, feeding the child in the same way, in the same place, at the same time every day, in other words the establishment of good conditioned reflexes. The child's hunger and the mother's secretion, the pain of want and the means of satisfaction, are then simulataneous and the " summum bonum " is attained.

Then there is the dogma that it is wrong to feed a child during the night. For whose benefit has this been laid down ? Assuredly for the mother's and father's and not for the child's. Suppose that he can be trained to go through the night with an unbroken sleep, then that will be for his parent's comfort and convenience no doubt ; and it is a fact that many children can be so trained and will continue to thrive. But to wake by day and to sleep by night is an acquired habit that belongs to the civilised adult : a baby on the other hand is naturally a polyphasic sleeper, that is he sleeps and wakes in snatches like a puppy or a kitten. Pangs of the hungry stomach, contracting every four hours during the day, may occur just as often during the night, and when they happen, set him howling. Then, if his need is not met, there is tumult, the luckless creature wails inconsolably, neighbours bang on the wall, father curses, mother cries and she comes to us to beg a sleeping draught. Take away our dogma, and this unhappy situation would never arise. If the child will readily submit and learn to sleep like an adult, let him, provided that the real reason for the practice is understood : if not, he must be treated wisely according to the needs of his nature. Here again a questioner who invites confidence on the subject will gradually come to know that many children *are* fed during the night, parental love being after all stronger than dogma.

How have we fallen into these errors ? The answer suggests itself at once. All of us, medical men and nurses, were trained up in hospitals. We diligently

learnt how many pints of milk the sufferer from typhoid must take in the day, at what intervals the feeds must be given and how the poor wretch's diet was to be varied at appropriate times by chicken broth and weak tea. We were confronted with patients that had peptic ulcers, who must be fed on five ounces of milk every hour, with little treats perhaps of red currant jelly and Cream of Wheat, or whatever the regimen allowed. Then again our attention was drawn to such points in the diets of diabetics as that twelve ounces of vegetables of Group A are equivalent to one and one-third of an ounce of vegetables of Group E and that a third of a section of Vitaweat is equal to one Energen roll. For long our eyes were fixed on the sick and suffering; with earnest scrutiny they contemplated the rigid rules of authority, which only now are beginning to be bereft of some of their absurdities. Then when we lifted them and turned them towards the free and happy pair, we were blinded at first by the after-image and did not see what we were looking at. Illness means fear and fear needs authority: but with such things as these the healthy, cheerful and beautiful function of motherhood has nought whatsoever to do.

And then there is the dogma that a child must be weaned from the breast at nine months. Examine this statement as an Epicurean and see how baseless it is. The child has a natural desire for the breast, the mother the means of satisfying the want, and the path for both is to the goal of living things. Feeding will cease when the child loses the want or the mother no longer has the means or inclination to fulfil it. A child *can* be weaned at any age, but the time to choose is when need arises or prudence dictates. This time is an event, subject to movement, not an inherent property nor a fixrure. What is certain is that before the days when mothers of families could get cows' milk almost for the asking, children were breast-fed for a much longer time than they are now. Lucretius, for example, in the course of proving that such fabulous creatures as the Centaur could not exist, remarks that the horse at three years of age is in the flower of his strength, whereas the boy still feels for the milky breasts at night. In this fine old copy of the poem in my possession, Jacob Tonson, 1712, there is a picture of a woman dexterously directing streams of milk from two breasts simultaneously into the mouth of a little boy aged about eighteen months. The same idea can be seen in Rubens' picture "Peace and War" in the National Gallery. In the background are the dark, catabolic males in the panoply of war; in full light in the foreground are the anabolic females. One, representing the first phase in the sexual cycle, displays the glossy skin of her back, while her rich attire slips off her ample hips; the other, representing the final phase, is the benign mother, who is squirting a long stream of milk from her bare breast into the open mouth of a little boy standing beside her; and down his chin trickles the rich repast. (Yet, lest Woman be over-proud, some haggard Eris or Bellona hovers over all.) Rogers translates a Greek epigram telling how a mother saved her little boy's life by proffering the attraction of her breast.

> While on the cliff with calm delight she kneels,
> And the blue vales a thousand joys recall,
> See, to the last, last verge her infant steals!
> O fly—yet stir not, speak not, lest it fall.
> Far better taught, she lays her bosom bare,
> And the fond boy springs back to nestle there.

In this edition, Cadell and Davies, 1814, there is a pretty wood-cut, which portrays the mother kneeling and the little boy standing as he applies his lips.

Turning to the testimony of our chief poet, one thinks of Juliet, who was weaned by the nurse when she was all but three years old, on the day of the earthquake.

> Of all the days of the year upon that day :
> For I had then laid wormwood to my dug,
> Sitting in the sun under the dove-house wall.

In my student days the mothers of the poor in London generally fed their infants for about two years and this, I believe, is the normal time. They were glad to do so, partly because they could afford no other milk, partly because they did not conceive so readily as long as they continued suckling. Not many maintain this practice to-day and scarcely any emulate the feat of Juliet's nurse. Exempt from dogma the period of breast-feeding would actually be shorter now than it used to be, but it would be very variable. There is usually no need for prolonged feeding, but neither is there for rigidity. You may wonder why rigidity exists : you should follow the advice of Jeeves and study the psychology of the individual ; or you may think of Juliet with three years of breast-feeding behind her.

> O, she doth teach the torches to burn bright !
> It seems she hangs upon the cheek of night
> Like a rich jewel in an Ethiope's ear ;
> Beauty too rich for use, for earth too dear !

Nowadays the natural and necessary pleasures of breast-feeding are in competition with others that are frankly κεναί, or vain, such as leaving the baby with granny and going to " the pictures " or the continual stimulation of days spent in office or factory, what the sage would have called a mere γαργαλισμός, or tickling. " You know what it is, doctor : it's the pictures and it's the figger," said a shrewd old Borough woman. The pleasure that lies in breast-feeding has not been given enough emphasis. Nowadays the scientist in us predominates over the artist : he is a man full of warning but empty of encouragement. " A dogma learned is only a new error ; but a spirit communicated is a perpetual possession," says Stevenson in his " Influence of Books." The spirit of Epicurus would see in this function a perfect example of the static pleasure, a recurring time of rest and relaxation accompanied by agreeable sensations and happy thoughts, and an identification with the generative forces of Nature.

> Hinc lætas urbis pueris florere videmus
> frondiferasque novis avibus canere undique silvas ;
> hinc fessæ pecudes pingui per pabula læta
> corpora deponunt et candens lacteus umor
> uberibus manat distentis ; hinc nova proles
> artubus infirmis teneras lasciva per herbas
> ludit lacte mero mentis perculsa novellas.

(Hence we see the joyous cities blossoming with children and the leafy woods ringing with the songs of young birds ; hence the kine, weary with their load of fat, lay down their bodies in the joyous pastures and the white milky juice trickles from their swollen udders ; hence the new-born offspring gambols playfully on weakly limbs through the soft grass and its little mind is thrilled with the pure milk.)

When the child has been weaned in the strict sense, that is accustomed to foreign foods, disaster may follow if the principles of Epicurus are violated.

Down all the long ages before our civilised state began one can see the child, at first fed by hand with whatever his mother thought was right, then, when he could crawl, grasping any food that lay about, tasting this and testing that, not without belly-aches, and so happily gaining experience. In this way the intake of food was exactly complementary to the *'επιθυμία*, or desire for food. But now all is changed. Mother chooses the food according to approved ideas, administers it at set times and decides how much the child should eat. He may submit to this regimen with perfect docility and that will be most satisfactory; but all unconsciously she has substituted her will for his desire and thereby she may cut away his natural pleasure. Then comes the true anorexia, no stretching out for one's self. Unassociated any longer with pleasure, eating ceases. A conflict then arises between the anxious mother and the rebellious child, with the result that food is actually loathed. It is a difficult strait and a sad, when one considers that those who get into it are often the most careful and solicitous mothers. It is a fault too that is commoner than it used to be, and scarcity of good food is the reason. "Imagine," said Sweet Anne, unfolding her perplexities, "that after many, many weeks, at last the butcher sends some liver: how Mother hovers o'er, eager to see the longed for prize devoured! And then the little wretch disdains it!"

There is nothing for it after this but faithfully to follow Epicurus. *Ablata causa tollitur effectus.* Take away the interference and the anorexia is removed. Out of the food that is available the child must now eat what he likes, when he likes, just as a kitten does or a puppy. No watchful eyes nor pleading voice must mar his choice. Pleasure must be the only guide, *dux vitæ dia voluptas.* After a while appetite will return and gradually he will come to eat his meals at normal times with other people. But it may be a hard lesson to learn. The mother's feelings are strong and deep and they govern a hundred little daily actions of which she herself is unconscious. Even when the truth is shown to her she may be incredulous. Then she wanders restlessly from one to another, trusting none, wasting her own and other's time, ever hopeful of finding the magic key that all the while reposes in her palm. Unfortunate! Has any woman ever heard of the rule of Thelema? I suspect not; for no female born ever reads Rabelais. "In all their rule and strictest tie of their order there was but this one clause to be observed,

DO WHAT THOU WILT."

Sleep is a function that is often overlaid in the same mistaken way. The desire for sleep is natural and necessary and the fulfilment is a wholesome pleasure. A healthy child, if nothing is done to interfere with him, will sleep as long as he requires. Frankly, it seems to me an absurd thing to concoct tables setting down how many hours precisely at every age a child should sleep. Over and over again one is confronted with a frolicsome child in superb health by a mother agitated because he will not sleep "as he ought." Let Nature be the guide, not some illusory rule of Nature! Happiness is then restored. "Oh, the relief," said fair Earine, "since you have told me that she can sleep when she likes!" Now may she say,

'Εστι μοι κάλα πάϊς, χρυσίοισιν ἀνθέμοισιν
ἐμφέρην ἔχοισα μόρφαν, Κλῆϊς ἀγαπάτα.

"I have a lovely child, fair her form as golden blossoms, Gloria the beloved." (Sappho.)

PLEASURE, MOTHER AND CHILD

But sometimes the parents have indulged the child foolishly in vain pleasures to the detriment of the natural and necessary, so that he becomes addicted to a night-life of excitement. The remedy lies in their own hands, but if they suffer much at night Nature can be judiciously assisted by drugs, such as a sleeping draught to be given at bed-time and again in the night if unseasonable wakefulness supervenes. Dwellers in London or other large city may have their own difficulties, especially in the slums.

Nam quæ meritoria somnum
Admittunt? Magnis opibus dormitur in urbe.

What chance of rest is there in a "buildings"? Only a millionaire could sleep in Rome.

As the child develops, the pleasures of the mind surpass those of the body and more and more skill is required to distinguish the true from the false. The foundation of all is to lead a virtuous life. *οὐκ ἔστιν ἡδέως ζῆν ἄνευ τοῦ φρονιμῶς καὶ καλῶς καὶ δικαίως.* One cannot live sweetly without living wisely, beautifully and righteously.

Know then this truth (enough for Man to know)
"Virtue alone is happiness below."—*Pope.*

Yet this old system of "sober, sweet Epicurean life," as Tennyson called it, has its defects, for it does not comprehend anything spiritual. On our present voyage, Youth on the prow and Pleasure at the helm, we have not had to concern ourselves with this aspect, content to refresh our minds and unlearn a few errors. Science, although she has been of great service to Man in banishing base beliefs that are unworthy of a reasonable person's esteem, yet is by herself not nearly sufficient for his needs. The poets are generally reliable guides; yet it is significant that, as religion has decayed, so a dreadful delirium has settled on the Muse of Poetry, just as she of Music is smitten with uncouth raspings and hootings—sometimes betwixt an Honegger and owl. Organized religion has been stained with terrible crimes, and even a philosopher may be a fool.

Who reasons wisely, is not therefore wise.
His pride in Reas'ning, not in acting lies.

One should never, of course, give good advice; but a wise man may make his own synthesis, searching for the Absolute Values, as they are called, wherever he can find them, like the old poet of Venusia,

Nullius addictus iurare in verba magistri,

not bound to swear to the bidding of any master.

Mother and Child, as you will have seen I hope, are the most cheerful subjects in Medicine. But though Medicine may be grave at times, it should never be grim. If you go to the Royal Academy, as you ought to go, to look at the assembled pictures of the Chantrey Bequest, you will see the wonderfully beautiful "Visit to Æsculapius" by Poynter and note that the right approach to Medicine is through art, science and philosophy. Even if you do not admire the pircture as much as I do, you must admit its dazzling superiority to Harley Street. At present, Mother and Child are almost the only avenue that gives you the right approach. Be happy then in your brief stay in the department of Child Health and be determined that, when you come to practise, you will not leave out of account this joyful and important branch of Medicine.

Obituary

SIR EDMUND SPRIGGS, K.C.V.O., M.D., F.R.C.P.

SIR EDMUND SPRIGGS, who died at Ruthin Castle on February 4th, won an open scholarship to Guy's. After qualifying M.B. with honours in 1896, he took his M.D. two years later, and succeeded Gowland Hopkins as Demonstrator of Physiology and afterwards became a Demonstrator of Pharmacology in this hospital.

While holding the Gull Research Studentship and working in the Kossel's Laboratory at Heidelburg, he published his first paper on Peptic Activity in 1901. The following year he was appointed Assistant Physian to the London Chest Hospital and later to the Victoria Hospital for Children, Tite Street. In 1903 Spriggs, while working on diabetes, published, with A. P. Beddard and M. S. Pembrey, a work confirming the earlier observations of Minkowski and Kraus. In 1904 he was appointed Assistant Physician to St. George's Hospital (where later he became Dean of the Medical School), and the following year was elected F.R.C.P. In 1906 he gave the Oliver-Sharpey Lectures on "The Bearing of Metabolism Experiments upon the Treatment of Some Diseases," while in 1909 he published his first paper on "The Treatment of Gastric Ulcer by Immediate Feeding."

Spriggs himself became ill in 1911 and through his illness met Dr. David Lawson, who offered him the post of Senior Physician at a new clinic for gastric disorders. The new clinic, Duff House, first at Banff, ten years later moved to Ruthin Castle, N. Wales, where it became so well known.

Towards the end of the first World War, Spriggs became Medical Advisor to the Ministry of Food, after which he wrote the first of a succession of papers, together with O. A. Marxer, on Diverticulosis and Diverticulitis. In 1933, Spriggs in the Croonian Lectures reviewed 500 cases of headache and as recently as 1943 wrote a paper on Polyps of the Stomach and Polypoid Gastritis. In all, he wrote over 100 papers.

He was a beautiful speaker in public, with apparent ease talking extempore in such a way that a reporter could take down a verbatim report and find it complete and grammatical. He won the friendship and admiration of innumerable patients.

Guy's Diary

MARCH

ACADEMIC

Exhibition. Surgical Dept. "Twenty Questions.

14th. Exhibition. Gordon Museum. "Congenital Heart Disease."
1.00. Dr. Munro. Clinical Lecture. "Recognition of Depressive Illness."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. R. C. MacKeith. Department of Child Health. Postgraduate Lecture. "Adolescence." Preclinical Classroom.

15th. 12.00. Dr. McArdle. Neurological Demonstration. Preclinical Classroom.
5.00. Endocrine Lecture. Preclinical Classroom.

16th. 1.00. Dr. Waterfield. Hæmatological Lecture. Hæmatology Dept.

17th. 4.30. X-ray Meeting. Gordon Museum.

18th. 1.00. Dr. J. H. Hutchison, O.B.E., M.D., F.R.C.P. Clinical Lecture. "Epi-Tuberculosis.
2.15. Med. Dept. Clinico-Pathological Conference. Pathology Lecture Theatre.

21st. 1.00. Mr. Batchelor. Clinical Lecture. "Osteochondritis and Epiphysitis."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Mr. R. Lawrie. Dept. of Child Health. Postgraduate Lecture. "Tuberculous Glands in the Neck," Preclinical Classroom.

22nd. 1.00. Dr. Mann. Clinical Lecture. "Colitis."
1.00. Mr. R. Lawrie. Clinical Lecture. "*Union of Fractures.*"

24th. 4.30. X-ray Meeting. Gordon Museum.
1.00. Dr. Kauntze. Clinical Lecture. "Gout."

25th. 2.15. Med. Dept. Clinico-Physiology Meeting.

26th. 10.00. Surgical Dept. Clinico-Pathological Meeting. Anatomy Theatre.
1.00. Dr. McConnell. Clinical Lecture. "Anæsthesia for Infants and Young Children."

28th. 3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Mr. O. G. Morgan. Dept. of Child Health. Postgraduate Lecture. "Squint in Childhood." Preclinical Classroom.

SPORT

15th. 7.45. Theatre Club. "Candida."

16th. 5.30. Theatre Club. "Candida."

17th. 6.30. Theatre Club. "Candida."

18th. Rifle Club, "A" Team *v.* Mitcham and Tooting "B."
7.45. Theatre Club. "Candida."

19th. Rugby XV. *v.* Gloucester (Gloucester).
Hockey 1st XI. *v.* Romford (Away).
Hockey 2nd XI. *v.* Bromley.
Hockey 3rd XI. *v.* Bromley.
3.00. Theatre Club. "Candida."
7.45. Theatre Club. "Candida."

23rd. Rugger—Inter-Hospitals' Cup Final (Richmond).

25th. Rifle Club "A" Team *v.* G.P.O. "E."
Rifle Club "B" Team *v.* "E" Coy. 2nd Northants H. G.

26th. Rugby XV. *v.* Old Whitgiftians (H.O.P.).
Hockey 1st XI. *v.* Rochester and Gillingham (H.O.P.).
Hockey 2nd XI. *v.* Rochester and Gillingham (Away).
Hockey 3rd XI. *v.* Rochester and Gillingham (Away).

Guy's Hospital Dental Society

THE Annual Clinical Meeting of the Dental Society was held on Saturday, 5th March. Throughout the morning and afternoon sessions extensive and impressive displays were arranged. Selected operations were performed before large audiences in the main theatres, exhibitions were staged in the Dental Department on orthodontics, prosthetics, radiology, pathology, bacteriology, photography and research, films were shown in the Anatomy Theatre and back in the Department a number of clinical cases afforded practical and enlightening demonstrations.

This meeting, providing both for social re-union and, at the same time, educational revision and advance, proved even more successful than those held previously. It is estimated that more than five hundred people were present during the day. Credit and commendation is due to all those responsible for the event. A standard was set which others might well emulate.

Socially the programme culminated in the evening with a dinner at the Park Lane Hotel. Col. and Mr. H. H. Kenshole received three hundred and seventy members and guests. After the loyal toasts given by the President, Mr. W. G. Senior proposed "Guy's Hospital and Schools." Reference to various aspects of the National Health Service drew numerous comments from those assembled. Mr. W. D. Doherty, replying on behalf of the Hospital in his capacity as Superintendent, pleaded quandary. If unable, as he said, to speak on behalf of the buildings, the staff, the administration or even the nurses at least his claim to accept the toast in "the spirit of Guy's" met with general acclamation. That spirit, he emphasised, largely meant "putting more into the Hospital than one got out of it." Mr. E. B. Dowsett, for the Schools, pointed out that October, 1949, would mark the silver jubilee of the dental establishment at Guy's and suggested that an appropriate celebration might mark the occasion since the original plans for the jubilee in 1939 were brought to nought by "the intervention of circumstances beyond immediate control."

After Mr. Kelsey Fry had proposed "The Visitors," making particular reference to those present from the University and the Grants Committee to whom they were so much indebted, Dr. Fish, in the unavoidable absence of Lord Webb-Johnson owing to illness, responded in terms at once profound and humorous. What mattered, he declared, was not so much the material provision and administrative machinery of the dental service in this country as the character, ethics and integrity of those who continued to represent the profession in practice.

Mr. Doubleday spoke in warm tones of the President and Col. Kenshole expressed his gratitude to the committee of the Society and to all those at the Hospital upon whose willing co-operation so much depended.

Formal proceedings then came to an end, but not so the evening. Adjournment to other surroundings, stimulating and convivial, allowed for further discussion, personal, social and in reminiscence and, as the President had commented earlier, for respect of those judicial dispensations not entirely confined to the legal bar.

G.

Correspondence

The B.M.S.A.

SIR,—The letter in your last issue dealing with affiliation with B.M.S.A. cannot be allowed to escape without comment.

The author of the letter was unfortunately led by his enthusiastic antagonism to misquote the original statement and one would generally wish for an intellectual rather than an emotional approach to this question of B.M.S.A. affiliation.

It is revealing to learn that apparently on the basis of their somewhat inadequate experience of B.M.S.A. matters in 1943, the author and his associates not only decided against affiliation then but aspire to assert their authority now in 1949.

In contrast to this and in reply to his allegation of secular interest, it may be stated that the Students' Union desires to carry out only the wish of the majority and in actual fact at the last referendum 155 to 119 voted for affiliation with B.M.S.A. To count uncast votes is presumptuous and the Annual General Meeting, realising this, instructed the Students' Union Council to hold a further referendum. It was in an effort to obtain a larger poll that the facts on B.M.S.A. were recently published at the request of the Students' Union Council by the liaison officer for the 155 Guy's members of B.M.S.A.

The need for a body such as B.M.S.A. has been repeatedly encountered by the Students' Union in its work and it is felt that matters such as the revision of grants for ex-service students and houseman, and student exchange could be more efficiently dealt with by B.M.S.A. than by any individual student body.

Finally, that Guy's policy should be influenced either by the seventeen students' unions affiliated or the seven not affiliated with the B.M.S.A. is, we feel, to be deprecated.

Yours, etc.,

JACK PALMER,
Chairman.

DERRICK DODSHOW,
Hon. Secretary.

The Students' Union,
Guy's Hospital, S.E.1.

Out-Patient Appointment List

SIR,—Will you please amend the Out-Patient Appointment List, published in the last issue of *The Gazette*, as follows :—

Tuesday afternoon—for " Asthma " read " Asthma (treatment only)."

Wednesday morning—delete " Asthma."

Thursday morning—add " Asthma."

Yours, etc.,

Dr. A. ANGUS,
Admitting and Records Officer.

Guy's Hospital, S.E.1.

Reviews

Modern Treatment Year Book, 1948. Edited by CECIL WAKELEY. The Medical Press. *Price* 15*s*.

IMAGINE a medical journal which each week contains one good article summarising, for the General Practicioner, the present state of knowledge on the diagnosis and treatment of some disease, written by an acknowledged pundit on that subject. At the end of thirty-eight weeks imagine that you cut out these articles and paste them into a book. This would be the book.

H.A.R.

Infra-Red Irradiation. By WILLIAM BEAUMONT. 3rd Edn. Lewis. *Price* 8*s*. 6*d*.

DR. BEAUMONT presents a clear and concise description of Infra-Red Irradiation. He covers the physics of thermogenic radiation adequately using script terminology.

The account of its physiological effects upon the human body indicates that a considerable amount of further experimental and clinical investigation will be necessary before the action of this irradiation is fully understood. Heat in some form has been used throughout the ages for the relief of pain and the author stresses this action of infra-red irradiation rather than the cure of any underlying condition.

K.W.M.P.

Minor Surgery. By R. J. MCNEILL LOVE. 3rd Edn. Lewis. *Price* 22*s*. 6*d*.

THIS book is intended to be a guide to the senior dresser and hospital resident, dealing with subjects which become second nature to the experienced but are problems to the initiate, namely, examining the patient, antisepsis, bandaging, anæsthesia, and everyday injuries.

One would have liked some mention of the anticoagulants and the Rh factor, subjects very much in the mind of the modern house-surgeon. Also, in the section on post-operative chest complications, the accepted view of atelectesis might have been stressed rather than a description of bronchitis as the most common complication.

A.J.D.

Modern Methods of Mental Treatment. By J. W. FISHER. 1st Edn. Staples Press. *Price* 6*s*.

THIS is a brief review of the common forms of physical treatment—electro-convulsive and insulin therapy, narco-analysis, drug treatment, etc.—employed in the treatment of mental disorder, with a note on psychotherapy ; an outline for each procedure is given, which is appropriate for the nurse or elementary student.

O'N.

Eden and Holland's Manual of Obstetrics. By ALAN BREWS. 9th Edn. Churchill. *Price* 42*s*.

IT is eleven years since a new edition of this well-known London Hospital textbook was last published. Here it is, and in every way it is an extremely fine volume, which the publishers must have passed through their hands with unusual rapidity, because it is still up-to-date.

The illustrations, drawn from a multitude of sources, are excellent, and the text, if somewhat chatty, is abundantly clear in exposition. Each section concludes with a well chosen bibliography, and the whole book with an excellent chapter on operative obstetrics. One feels that while nothing obsolete has been included, nothing new and of proven worth has been left out. It can be thoroughly recommended to anyone who can face the price—and the well nigh eight hundred pages.

H.A.R.

An Introduction to Surgery. By RUTHERFORD MORISON and CHARLES F. M. SAINT. 4th Edn. Wright. *Price* 42*s.*

THIS book will always be a happy reminder of Rutherford Morison's sound teaching of surgical principles. Mr. Saint has been able to add many excellent photographs of advanced diseases, seldom seen in this country nowadays, from his clinics in Cape Town.

The occasional mistake and unorthodox opinion may confuse the undergraduate student; and one may wonder whether controversial methods of treatment are ideal in an introduction to surgery.

A book well worth reading.

A.J.D.

Diseases of the Ear, Nose and Throat. By DOUGLAS G. CARRUTHERS. 2nd Edn. Wright. *Price* 25*s.*

THIS is a short textbook—344 pages—intended for the student and the general practitioner. We are seeing its début in this country, the first edition having been published in Australia only.

Not everyone will agree that there is a place for this kind of book on a special subject. The student should not have time to read it all, and yet it cannot pose as a work of reference.

Some of the illustrations are bad. The next edition must correct, for instance, the muddle on page 297.

L.F.W.S.

Notes on Infant Feeding. By FLEMING & GRAHAM. 3rd Edn. Livingstone. *Price* 3*s.*

THIS is one of many excellent little books on Infant Feeding. On the subject of artificial feeding, detail is good, but the actual method of calculating the amount required for practical purposes, according to the "expected" weight, could be much simplified. More detail on feeding premature infants would be useful. It is surprising to find no mention made of test weighing in discussing quantitative disorders of breast feeding.

J.U.M.

First Year Physiological Technique. By ALEX COMFORT. Staples Press. *Price* 7*s.* 6*d.*

THIS lucid little book emphasises the practical advice of the Demonstrator and includes certain valuable instruction he might omit.

The beginner should pay particular attention to the first chapter dealing with the physiological attitude and the student's conduct in the laboratory.

W.G.

Aids to Practical Nursing. By MARJORIE HOUGHTON. 6th Edn. Bailliere, Tindall & Cox. *Price* 5*s.*

THIS is a helpful textbook for the Nurse in training, giving concise information on the practical aspects of nursing. The book is well indexed and clearly written. Chapter I. gives an interesting account of the history of nursing and of nursing affairs up to the present day.

A.F.

The following book has also been received:—

Aids to Hygiene for Nurses. By EDITH M. FUNNELL. 3rd Edn. Bailliere, Tindall & Cox. *Price* 5*s.*

Sport

RUGBY

INTER-HOSPITALS' CUP—SEMI-FINAL

GUY'S *v.* MIDDLESEX

at Richmond. Drawn 3—3.
3rd March, 1949.

Not a great day for Guy's, I think, sums up the XV's performance in this match. Nothing seemed to go right and although the ball perhaps was not bouncing well for Guy's they certainly survived to the replay by lack of appreciation of the position on the part of the Middlesex backs.

It was a bitterly cold day as the teams lined up thirty minutes late after a substitute referee had been found, with Guy's against both sun and wind. Right from the start Middlesex attacked and usually their weight forward had Guy's on the defensive for the first ten minutes. After this, however, the Le Clus' brothers brought relief and Gray continued a good movement to be taken into touch on the Middlesex '25. Play then became fast and furious changing ends rapidly. Middlesex wasted two chances, one by Fairgreve who, having broken clear, was well tackled by Lewis trying to turn inside him instead of using his speed to round him (and this from an Olympic sprinter) and one by McIver who kicked over the dead ball line in attempting to beat Lewis. An unfortunate offside—a fault which was rarely detected by the referee but clearly by the vociferous Middlesex supporters—gave them a 3-point lead which was reduced again within a few minutes.

Heber broke and dribbling up to the full-back was only partly checked and Kirkbride and Hobbs took it on for the former to score. So to half-time with the Guy's supporters optimistic.

Hopes were, however, rudely shattered. Middlesex started off badly and Guy's pressed their line for ten solid minutes with little relief, but a try evaded us. After this Middlesex gradually came up again so much so that they completely dominated the rest of the play. The Guy's forwards were beaten in tight scrums and line-outs and with de Plessis very much a passenger and Lewis with an injured shoulder, did well to hold them. This was mainly due to grand work by our back row trio, Eckstein, Raderman and Davies. The only true scoring chance came five minutes from time when F. Le Clus kicking ahead fielded and was only a yard short when caught by a magnificent flying tackle from behind. So to the final whistle—a debate on extra time and a negative answer and the decision to replay on Wednesday, the 9th March.

STOP PRESS

Replay—Guy's 3 (try), Middlesex 3 (penalty).

Further Replay—Richmond,

TUESDAY NEXT, MARCH 15th.

ASSOCIATION FOOTBALL

GUY'S *v.* READING UNIVERSITY

at H.O.P. Won 5—1.
23rd February, 1949.

Guy's avenged in no small way their defeat at the hands of Reading University earlier in the season, though in fairness it must be said that our opponents were not at full strength.

The University were soon in trouble when their 'keeper mis-handled a long shot from Lipington, and Lewis was on the spot to force it home. Guy's continued to have most of the game without increasing their lead until a good Whitaker shot

struck an upright and the rebound was prevented from entering the net by a defender's hand. Lipington showed how a penalty should be taken from the ensuing spot kick. The third goal which completed the first-half scoring came from an indirect free kick, and was scored by Skaith who went "in off" Whitaker's back.

The second half saw much ineffective football which was only enlivened by three good goals—two by Guy's and one by Reading. Skaith got both the Guy's points from well placed crosses by Oldfield on the left wing. All members of the defence played well whilst Lewis and Skaith were the live wires of the attack.

2nd ROUND HOSPITALS CUP
GUY'S *v.* MIDDLESEX HOSPITAL
at Chislehurst. Won 6—1.
26th February, 1949.

Guy's won the toss and took advantage of the slope in the first half. Both teams took sometime to settle down, and it was obvious that Guy's would have to change their style of football to counteract the cup tie football that Middlesex were playing. After 15 minutes play Guy's took the lead when Sturdy picked up a loose ball, beat two opponents and scored with a very good shot. He repeated this shortly afterwards when he received the ball after some good half-back play. Generally the game continued to be scrappy, but the Guy's defence was in good form. Young and Fearn putting in some particularly good work. Half-time came with Guy's leading by two goals to nil. In the second half playing up the slope Guy's combined much better and gave the Middlesex defence a very harassing time. Lewis, the Guy's centre forward, scored three beautiful opportunist goals in this half, and full credit must go to the inside forwards and wing half-backs for laying the foundation of these goals. A further goal was scored by Skaith, which also was a fine effort. Guy's eventually ran out winners by 6 goals to 1, Middlesex obtaining a consolation goal ten minutes from the end. Although the Middlesex team were very scrappy and lacked drive, full credit must go to the Guy's XI. for such a convincing victory. Guy's meet Royal Dental and Charing Cross Hospital in the Semi-Final and on this form, should once again reach the Final, and if St. Mary's are their opponents, all the team are determined this year to reverse last year's final result.

Team: A. Fearn, D. Lipington, W. Howells, E. Newton, J. F. Young, P. A. Swift, R. Skaith, D. E. Sturdy, N. I. Lewis, J. C. Leckie (Capt.), D. L. Oldfield.

GUY'S *v.* BIRMINGHAM UNIVERSITY
at Birmingham. Lost 1—3.
Wednesday, 2nd March, 1949.

Guy's met their masters when playing Birmingham University, and were well beaten by a team who served up attractive football.

Guy's commenced as if their hastily consumed lunch just prior to the kick-off was telling upon them, and Fearn in goal was kept busy, if not seriously troubled, until a penalty gave the University the lead. Guy's soon equalised through Sturdy who scored an opportunist's goal from a clever Newton back-heel. This concluded the scoring in the first-half and their improved showing immediately prior to the interval led one to anticipate a Guy's victory. These fond hopes were rudely shattered when almost immediately from the restart, Birmingham scored a good goal, and thereafter Guy's were never in the picture. Fearn made a miraculous save from a short range header, and great work by Lipington, Young and Howells repelled numerous attacks, and the only other score came from a long, rather speculative drive, which appeared as though it should have been stopped.

Once again our strong tackling defence deserves great credit, but the forwards, lacking the services of Lewis and Skaith, looked very inept, and bereft of ideas on combined movements in comparison with our opponents.

Our thanks are due to the University for their hospitality, and to our hard working Secretary, D. G. Matthews, whose efforts did so much to make the round trip such a social if not footballing success.

SOUTHERN AMATEUR LEAGUE
GUY'S *v.* CUACO
at H.O.P. Won 7—3.
19th February, 1949.

GUY'S *v.* OLD LYONIANS
at West Harrow. Won 4—3.
5th March, 1949.

Guy's made amends for their earlier defeat at H.O.P. by the Old Lyonians by beating them on their own ground 4—3.

After they had taken a while to settle down on this rather undulating heavy pitch—Guy's gradually asserted themselves and deserved their 1—0 lead (scored by Sturdy) at half-time. Immediately on restarting Lewis scored a cleverly planned goal without one of the opposition touching the ball. This was followed by a goal from Sturdy who was on the spot to drive home, when the goalkeeper fumbled a Lewis shot; and another when Whitaker harassed a defender to deflect into his own goal an accurate Skaith corner.

With a confortable 4—0 lead Guy's slackened (was it the Birmingham trip telling its tale?) and a series of alarming mistakes enabled the Old Boys to score three goals, and from being in an unassailable position Guy's were most thankful to hear the final whistle.

Leckie showed his versatility by proving a capable deputy for Young (injured) at centre half, whilst Lewis and Sturdy are working up a fine understanding which ably backed by the remainder of the forward line is producing the goals that were not forthcoming in the earlier part of the season.

GUY'S THEATRE CLUB

The Theatre Club will present George Bernard Shaw's "Candida" from March 15th for one week, as follows:—

Tuesday, 15th	..	7.45 p.m.
Wednesday, 16th	..	5.30 p.m.
Thursday, 17th	..	6. 30 p.m.
Friday, 18th	..	7.45 p.m.
Saturday, 19th	..	3.0 p.m. and 7.45 p.m.

Tickets may be obtained from the Students' Union Office between 12.30 and 1.30 p.m. daily. Admission free.

A number of people who received formal invitations, have completed and returned the cards provided, but have omitted to sign their names. Would anyone who is aware of having done this, please communicate with the Box Office to confirm the booking, and anyone about to return a card, please add his name.

BOXING CLUB

The Annual Boxing Tournament provided a large crowd with a highly entertaining evening's sport at the Seymour Hall on February 22nd.

In addition to the team match against St. Mary's Hospital, Guy's provided two competitors in the series of six special contests in which several leading amateur boxers took part. The Open Novices competition provided two further hard bouts.

In the special contests—

W. M. Sheeran (Guy's) beat R. Jacobs (Devas Institute A.B.C.) on points.

Exhibiting his usual polished style in combination with hard punching, Sheeran easily overcame a skilful and more experienced opponent.

R. C. Thompson (Guy's) beat C. Raven (London Transport A.B.C.) on points.

After flooring his opponent in the 1st round, Thompson's fast punching and powerful right-hand gained him a well-deserved victory.

In the Team Match—

Guy's beat Mary's 5—1.

A. Atkinson (Guy's) stopped G. Wakefield (Mary's) in the 2nd round.

By skilful tactics and clean punching, Atkinson found no difficulty in dismissing his adversary in the 2nd round.

M. Griffiths (Guy's) beat M. Williams (Mary's)—stopped in 2nd round.

Griffiths punished his opponent heavily from the start. In the second round he used both hands with such effect that it was necessary for the referee to intervene.

E. Sonnenfeld (Guy's) beat J. Lunn (Mary's) on points.

In a close match, Sonnenfeld's clean hard punching enabled him to gain a points decision. Credit is due to Sonnenfeld for helping us by boxing at very short notice.

D. Lipington (Guy's) lost to J. Bradford (Mary's) on points.

This contest provided one of the best team bouts. Against a tough hard-punching opponent, Lipington's superb footwork and body-swaying enabled him to make Bradford miss on numerous occasions. His skilful tactics undoubtedly saved him from heavier punishment. The best loser of the evening.

N. St. John (Guy's) stopped P. Storey (Mary's) in the 1st round.

After recovering from an initial savage attack by his opponent, St. John picked the ideal moment for a beautiful right cross which floored his man in no uncertain manner.

M. Halamandres (Guy's) beat W. Young (Mary's) on points.

A cool head and some solid punching enabled Halamandres to withstand Young's rushing tactics and to gain a clear victory.

The prizes were presented by Mr. J. Wyatt, President of the A.B.A.

The members of the Boxing Club extend their sincere thanks to all those who contributed towards the success of the evening, especially to Colonel Waley, Professor Rushton and Mr. McNair. For much detailed administrative help we are grateful to Mr. Notley and other members of the Counting House and to Mr. G. A. R. Winston. The latter, by his unstinting energy and organising ability, rendered us invaluable assistance.

F.G.E.

CLUBS' UNION

Provisional figures for the voting in the referendum conducted by the Clubs' Union Council on the subject of compulsory membership have been declared as follows :—

TOTAL VOTES 599

Ex-serv.	Non-Exs.	Medical	Dental
321	278	356	243

COMPULSORY MEMBERSHIP

	Ex-serv.	Non-Exs.	Total.
Yes ..	211	106	317
No ..	110	172	282

PERIOD OF COMPULSION

	Ex-serv.	Non-Exs.	Total.
5 Years ..	226	207	433
Indef. ..	95	71	166

MEDICAL

	YES.		NO.	
	5 yrs.	Indef.	5 yrs.	Indef.
1st.—Ex-serv.	14	5	11	4
Non-Ex.	5	3	14	0
Total	27		29	
2nd—Ex-serv. and Non-Ex. 3rd.	35	19	33	4
	9	5	17	4
Total	68		58	
Clinical—				
Ex-service	11	12	20	2
Non-Ex.	28	26	63	12
Total	77		97	

DENTAL

	YES.		NO.	
	5 yrs.	Indef.	5 yrs.	Indef.
1st.—Ex-serv.	20	8	7	4
Non-Ex.	1	3	10	1
Total	32		22	
2nd—Ex-serv. and Non-Ex. 3rd.	46	24	9	6
	11	4	15	3
Total	85		33	
Clinical—				
Ex-serv.	14	3	6	4
Non-Ex.	6	5	28	5
Total	28		43	

Totals—1st 110
2nd and 3rd .. 244
Clinical 245
Spoiled Votes .. 9.

These results will be considered by the Council at a meeting to be held in the near future, and a decision will then be taken regarding further action.

G. D. CHANNELL,
Hon. Secretary.

Hospital Information, etc.

NOTICES

THE ROYAL INSTITUTE OF PUBLIC HEALTH AND HYGIENE

The following lectures are to be delivered in the Lecture Hall of the Institute, 28, Portland Place, W.1

March 23rd: "The Social Significance of Geriatric Rehabilitation," by L. Z. Cosin, F.R.C.S.

April 6th: "The Growing Family, under Modern Home Conditions," by Leslie G. Housden, O.B.E., M.D.

CAR PARK

A Hospital Car Park, situated on the bombed site in the space between St. Thomas's Street and Maze Pond will be opened for use on **Monday, March 21st, 1949.** After that date, the roadway in front of Hunt's House, Nuffield House, Dental School, etc., will be no longer available for parking cars.

The Front Quadrangle will be reserved for the convenience of Governors, members of the Visiting Staff, etc., paying only short visits to the Hospital. The cars of all other Hospital and School staff and students should be parked in the Car Park.

In order to prevent unauthorised parking, it will be necessary to obtain a printed permit card from the Superintendent's Office before the park can be used. This card must be produced on request, on entering the park.

The Car Park will be open from 8 a.m. to 10 p.m. Monday–Saturday, but the Attendant will only be on duty from 8 a.m. to 6 p.m. from Monday–Friday, and from 8 a.m. to 12 noon on Saturday. After 10 p.m. the Car Park will be locked and the key deposited in the Front Porters' Lodge.

The Governors can accept no responsibility for the safety of, or damage to, cars (or their contents) left in the Car Park.

W. D. DOHERTY,
Superintendent.

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from registered Dental Practitioners for the post of **Full-time Assistant** to the **Visiting Dental Surgeons** to Guy's Hospital. Duties will comprise assisting with the Clinical treatment of patients referred to the Dental Department of the Hospital, and the instruction of students. The post will provide excellent facilities for a person who is studying for a higher degree or diploma. Salary £750 per annum, plus superannuation and family allowance (subject to revision after the publication of the Spens Report). Duties to commence as soon as possible after the 9th May, 1949.

Forms of application are obtainable from the Dean, Guy's Hospital Dental School, London, S.E.1, to whom applications should be sent not later than 8th April, 1949.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

PASS LIST

L.D.S.

FINAL EXAMINATION.

January–February, 1949.

Part I.—Surgery.

A. Black	M. B. Lacey
C. B. Bowes	A. P. Leech
D. G. Brett	J. G. Lloyd
D. G. Bunker	H. A. H. Ohlrich
C. M. E. Eugster	L. A. Rees
P. Griffiths	M. P. O'Reilly
J. D. Haworth	I. L. Roth
B. A. Hill	G. F. Thompson
M. J. Humphry	R. V. Warren
R. Karat	N. J. Wood
M. M. Keen	P. J. Wright

Part II.—Dental Surgery.

E. J. Annen	B. S. Saunders
C. M. E. Eugster	B. Schwartz
A. E. Jacques	R. E. Simmons
D. W. Leatherbarrow	T. K. Walker
C. B. Palmer	S. L. Woolgar

F.R.C.S.

PRIMARY EXAMINATION.

January, 1949.

M. D. Cremin	C. H. Kinder

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

February, 1949.

Pathology, Bacteriology and Forensic Medicine.
H. E. G. Dyer S. S. Mare
Medicine—W. G. Burvill-Holmes; D. J. Joubert.
Midwifery—J. T. Cecil.

Appointment.

Sir Heneage Ogilvie has been reappointed as a representative of the College on the Council of the Imperial Cancer Research Fund.

UNIVERSITY OF LONDON

EXAMINATION FOR THE ACADEMIC POSTGRADUATE DIPLOMA IN MEDICAL RADIOLOGY (DIAGNOSIS).

February, 1949.

Part I.

D. J. Chapman	R. P. C. MacDonald
K. E. Hodge	W. H. Smith

OXFORD UNIVERSITY

Doctor of Medicine.

The degree of Doctor of Medicine has been conferred on M. A. Partridge and J. A. L. Leeming.

APPOINTMENT

Dr. R. J. W. Rees, M.B., B.Sc., Scientific Staff, Medical Research Council, Farm Laboratories, Mill Hill, N.W.7.

VEN. ORDER OF THE HOSPITAL OF ST. JOHN OF JERUSALEM.

Serving Brother.

H. F. Sparling, M.B.E., L.M.S.S.A.

CHANGE OF ADDRESS

S. Carden, M.B., B.S., 24, Devonshire Place, W.1. (Tel.: Welbeck 8214 and 1449; after 6 p.m.: Battersea 0655.)

John Goodhart, M.B., B.Ch., 1, Garden Road, Sundridge Park, Bromley, Kent. (Tel.: Ravensbourne 6700.)

F. R. S. Knight, M.B., B.S., Coldharbour Cottage, Knowle Lane, Cranleigh, Surrey. (Tel.: Cranleigh 637.)

Sir Francis Shipway, K.C.V.O., Elmore House, Speen, Newbury, Berks.

BIRTHS

ROSEVEARE.—On February 22nd, 1949, in Paignton Hospital, to Barbara (née Webb), wife of T. A. Roseveare—a son (Simon Charles Adams).

YOUNG.—On February 10th, 1949, at West Park Hospital, Macclesfield, to Marie, wife of F. R. M. Young, M.B., B.S., of Park Green House, Macclesfield—a daughter (Rosemary Anne).

MARRIAGES

DENNY—McENTEGART.—On December 28th, 1948, at Southgate, N., Douglas Denny, B.Sc., to Pauline McEntegart, S.R.N., S.C.M.

DEATHS

ENSOR.—On February 10th, 1949, Cecil Arthur M.R.C.S., L.R.C.P., of 16, Ossulton Way, N.2, aged 75.

HALE-WHITE.—On February 26th, 1949, at Oxford, Sir William Hale-White, K.B.E., M.D., F.R.C.P., aged 91 years.

ORPEN.—Recently at Alice Cape Province, S. Africa, Leander Joseph John Orpen, M.A., M.B., B.Ch., D.P.H., formerly Director of the Pasteur Institute, Salisbury, S. Rhodesia, aged 72 years.

Eds. { H.A.R. R. G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

JUST a hundred years ago—on 15th March, 1849, to be precise—there appeared in the Medical Gazette the momentous and by now classical paper from the pen of Thomas Addison on *The constitutional and local effects of disease of the suprarenal capsules*. Only a short time previously he had read this before the South London Medical Society. Addison's name has gained a well-merited place in medical history, being eponymously associated not only with the endocrine disorder which he described so accurately but also with that type of anæmia to which he first drew attention and to which the uncompromising adjective "pernicious" is at present more often applied. Addison ward, moreover, is still the scene of that clinical medicine of which he was such a master and, since 1947, annual commemoration has been accorded in formal lecture through the generosity of Dr. H. Spon.

Born near Newcastle in 1793, Thomas Addison graduated at Edinburgh in 1815 where, it is said, "he acquired a reputation as a classical scholar, taking down his lecture notes in Latin." Thereafter he moved to London, working first at the Lock Hospital and then with Bateman the dermatologist. Entering Guy's in 1820 he attracted the attention of Benjamin Harrison and was appointed physician in 1824. Among his published papers were *The operation of poisonous agents in the living body* (1829), *The anatomy of the lung and pneumonia* (1837–1840)—in which he expressed what were then extremely original opinions on this subject, *Vitiligoidea*, written jointly with Gull, and *Disorders of the brain connected with diseased kidneys*.

During his lifetime, it is recorded, these articles did little to enhance his reputation. That, instead, rested upon his clinical ability, his outstanding personality and his widespread fame as a teacher. In contrast to his urbane colleague Bright, Addison was almost brusque and unapproachable. His students were said to have "worshipped him, and feared rather than loved him."

He married when he was fifty-four and, of that event, biographers say, "Just before the ceremony a storm, unknown to the wedding party, blew part of the church roof upon the altar and the fact was not discovered until they entered the church. 'Good God,' exclaimed Addison, 'is this not ominous?'" Nevertheless, he was to enjoy married life for thirteen years, retiring from his hospital duties in the spring of 1860 and dying at Brighton in the following June.

And the other Guy's men of that era? Thomas Hodgkin (1798–1866), a native of Tottenham, also qualified at Edinburgh, in 1823. He travelled widely on the Continent and then, back in England, became curator of the pathological museum and demonstrator in pathology at Guy's. His collection of specimens formed the basis of his *Lectures on the morbid anatomy of the serous and mucous membranes* (1836). Failing to secure election as assistant physician to the Hospital, Hodgkin resigned his post as pathologist but continued for some years in private practice. A member of the Society of Friends he devoted himself more and more to philanthropic efforts and, whilst travelling in the Orient with his friend Sir Moses Montefiore, contracted dysentery and died at Jaffa at the age of sixty-eight. His paper *On some morbid appearances of the absorbent glands and spleen* appeared in the Medico-Chirurgical Transactions of London in 1832. To the condition described therein Wilks gave the name "Hodgkin's disease" thirty-three years later.

Richard Bright (1789–1858), too, was a graduate of Edinburgh and, like Hodgkin, gained valuable experience in Berlin, Vienna and Hungary. Famed for his powers of observation and enquiry, renowned for his charm of manner and regarded as a highly skilled draughtsman—he illustrated his own notes and writings—Bright published his *Reports on medical cases selected with a view of illustrating the symptoms and cure of diseases*

by a reference to morbid anatomy in 1827. In these are to be found the admirable accounts of the renal conditions ever since linked with his name. But he was in no way a specialist. It is said there was " scarcely a disease of the body to which Bright did not pay attention." What is more, he was relentless in tracing the ætiology of those morbid processes that formed the object of his study. He retired from Guy's in 1843, being made consulting physician, and continued to reside in Saville Row until his death in December, 1858.

Gull (1811–1890) was another prominent figure of the period. He entered Guy's as an apprentice in 1837 and, following qualification in 1841, taught materia medica, natural philosophy, physiology and comparative anatomy, finally attaining to the lectureship of medicine in 1856. That he bore a strong resemblance to Napoleon I, both in outward form and manner, is always stated. What is not so well-known is that he was elected F.R.S. in 1858, received honorary doctorates from the Universities of Oxford, Cambridge and Edinburgh and was elevated to a baronetcy in 1872 in recognition of his services to the Prince of Wales when stricken with typhoid fever. Later he became physician-extraordinary to Queen Victoria. It was on 24th October, 1873, that he delivered to the Clinical Society of London his address *On a cretinoid state supervening in adult life in women*, not perhaps the first but still one of the most striking descriptions of myxœdema. Certainly it is the earliest record of this disease in which any reasonable attempt is made to suggest the cause.

Of Samuel Wilks, who became assistant physician in 1856, it is written he " was the first to make the profession grasp the fundamental importance of the study of morbid anatomy." His published works were numerous and his professional honours outstanding. Nowadays his name occupies a special place for Guy's men by virtue of his joint authorship with Bettany of an incomparable history of the Hospital. According to Garrison, it was the writings of Wilks that " really gave the diseases called after Bright, Addison and Hodgkin their place in English medicine."

No more than five have been mentioned biographically. Guy's owes it lustre, though, to many personalities. Babington, Hilton, Golding-Bird, Fagge and, above all, Astley Cooper, come to mind and, in recent years, Starling, Gowland Hopkins, Lane and Hurst. What a truly magnificent exhibition could be staged of the advances for which they were responsible · At all events, for an Addison centenary, something along these lines might be attempted.

But as a more permanent form of recognition probably no more valuable scheme could be envisaged than the further endowment of fellowships, studentships and the like, preferably in clinical subjects, under the ægis of the Medical School. The Fripp Memorial Fellowship, the Gull and Astley Cooper Studentships and the Lambrinudi Scholarship, along with a number of others, already exist. Scope remains for additions to the list. Such voluntary effort is still feasible and, indeed, to be encouraged, quite apart from and without fear of encroachment by the National Health Service.

Those whom Guy's honours nevertheless set a valuable example to which all can aspire. They demonstrated that real advance in clinical practice comes, not merely from painstaking and minute researches in specialised fields, important as these are, but from the acumen and independence of thought of those who, as Professor Newton has recently pointed out, can comprehend the whole range of wisdom and knowledge so that " a confused jumble of original discoveries . . . becomes sorted out into a straightforward story."

On another page appears a letter from a correspondent about the catering in the college. If the management of the " Spit " is not perfect, neither is the behaviour of its patrons beyond reproach. Misappropriation is an old military habit. Stealing is not recognised but " borrowing " is condoned. Presumably it is this practice which is applied to spoons and other articles, or maybe they just find their own way to the hostels.

The furniture, too, was attractive and of good order when first installed, but holes are burned in arm-chairs, feet are placed in the seats and the table-tops are disfigured in various ways. Only a few irresponsibles, we know, are to blame, yet their vandalism affects all the rest. In their own homes, it is said, they would not act in the same way; some of us are beginning to wonder.

So long as certain individuals persist in their utterly deplorable manners these otherwise justifiable complaints about the amenities and service tend to be vitiated.

Management of Head Injuries

A Clinical Lecture delivered at Guy's Hospital by R. S. LAWRIE, Esq., M.D. F.R.C.S.

GENTLEMEN,—Head injuries are usually classified as Open and Closed, but it is perhaps more useful to describe them as Localised and Diffuse.

Localised injuries may be produced by missile wounds or blows, such as a blow from a small hammer. They may thus be either open or closed and in either case an operation may be necessary to restore the normal anatomy by removing depressed and indriven bone fragments or foreign material such as mud, straw and clothing; and dead or contaminated tissue. The wound is then sutured and suitable prophylactic chemotherapy instituted. In these cases treatment is directed to the localised injury and the cerebral functions as a whole are often unaffected.

"Closed head injury" is a term implying a diffuse lesion produced by an injury consisting essentially of a sudden acceleration or deceleration of the head. This may be produced for example by a fall head-first on to concrete. The skull stops suddenly and the brain apparently goes on and is bruised by pressure against the inside of the cranium. The onward movement of the brain produces an area of reduced intracranial pressure at the opposite pole of the skull which results in ecchymoses, mainly on the surface of the brain. This is called a "contre-coup" lesion. If the injury is slight there may be no visible changes in the brain, but severer injuries cause œdema, contusion and laceration of the brain. The vault or base of the skull may be cracked, but generally the diffuse brain damage is of greater importance. A blow from a large hammer causing a sudden acceleration of the skull produces a similar effect on the brain. On the other hand, a similar blow, when the skull is rigidly supported, so as to exclude the element of acceleration does not ordinarily cause concussion.

Concussion means shaking together. I will quote Wilfred Trotter's definition of concussion, which he used in an oration to the Medical Society of London (B.M.J., 1924, i, 816) and which is very widely used :—

> "An essentially transient state due to head injury, of instantaneous onset, which manifests widespread symptoms of a purely paralytic kind, does not as such comprise any evidence of structural cerebral injury and is always followed by amnesia for the actual moment of the accident."

This is not a definition which would describe concussion to someone who had never seen it, but it emphasises some of its characteristic features and defines the use of the term so as to exclude some of the more serious injuries.

These are all included in the term "Closed head injury" and their severity may be approximately assessed by the duration of the post-traumatic amnesia—that is, the time which elapses before continuous consciousness and memory are restored; but this may be misleadingly prolonged by factors such as fatigue, sedatives, fits and psychological advantage.

The management of these cases may be considered under three headings :—

1. Care of the unconscious patient.
2. Measures directed to the head injury.
3. The recovery period.

1. THE UNCONSCIOUS PATIENT.

Airway. Most deeply unconscious patients snore if they lie on their backs and this interferes with their pulmonary ventilation and causes anoxia which may be lethal. The best thing is to turn them on their sides, and this will in addition prevent their inhaling their saliva and nasal secretions. An 8 in. nasopharyngeal tube, lubricated with analgesic ointment, will maintain the airway in a patient who is too restless to stay on his side, and is well-tolerated.

Mouth. Needs frequent cleaning with bicarbonate-soaked swabs to remove dried mucus and control sepsis which is sure to affect the chest.

Skin. Any unconscious or helpless patient will develop ischæmic necrosis of the pressure points on which he is lying unless his position is frequently changed and the pressure transferred from one area of skin to another in turn. The duration of ischæmia that skin can stand depends on the weight of the patient and the vitality of his tissues, but in practice, patients should be turned every two hours day and night or pressure

sores will occur. It is the doctor's responsibility to see that this is done and that the nurses understand how important it is; and in particular that it is better to turn the patient two-hourly night and day than to let him have a good night's sleep because he looks tired. One single failure may be fatal or cause a sore that takes months to heal. The necrotic area takes ten days to become black and obvious and is often incorrectly ascribed to some occurrence a week after the damage was done.

Incontinence. In males a valuable method to avoid a constantly wet bed is to fix a condom to the penis, attach a rubber tube to the end of the condom and drain the urine into a bottle outside the bed. Rectal incontinence is probably best handled by keeping the stools solid and giving enemas two or three times a week. Normacol may help to solidify the stools.

Restraint. Restless patients are said to be quieter if not restrained, but it may be difficult to put this into practice in a case with six porters holding him down. If the patient is likely to fall out of bed, it is best to put the mattress on the floor so that he has less far to fall. Restlessness is sometimes due to an overdistended bladder or a full rectum, which can be remedied.

Nutrition. Helpless patients are sometimes allowed to suffer or die from dehydration or starvation. This can only be prevented by a very careful and painstaking study of accurately kept fluid balance charts and diets. It is very important to find out and understand the nurses' particular feeding difficulties in each case. Some patients remain in coma or stupor for many weeks after a head injury and then make a spectacular recovery and one must always assume that such a recovery will occur if the patient's general condition is maintained.

Adequate fluid intake is still more important in patients taking sulfadiazine, to prevent the complication of anuria. The right attitude to this is well illustrated by an anecdote :—A ward orderly in charge of a tent of 40 cases of head injury was giving his report to the ward sister at the end of a very hot day.

" And I suppose thay have all wetted their beds ? " said Sister.
" Yes, I am afraid they have, Sister."
" That's very good," said Sister; " they must all be getting enough to drink."

2. MEASURES DIRECTED TO THE CLOSED HEAD INJURY.

Good X-rays of the skull are necessary and it is often convenient to take them on the way to the ward.

The C.N.S. must be examined and of course it is impossible to do a full neurological examination on an unconscious or struggling patient. The eyes, ears and facial nerve can be examined, remembering that bleeding from the ears suggests a fracture of the petrous bone and a path for infection of the meninges, particularly if there has been middle ear disease. The same is true of cerebro-spinal fluid rhinorrhœa in fractures of the anterior cranial fossa. Examination of the limbs should detect changes in movements, tone, deep reflexes and plantars, paying particular attention to any asymmetrical findings.

The purpose of one's examination is to assess the progress of the case and the need for operative treatment, and a good way to record the relevant observations is to institute a chart with a number of vertical columns, kept jointly by the nurse and the doctor.

Name.....

Date .....

Time	T	P	R	B.P.	State of Consciousness	Pupils	C.N.S.	Treatment

The nurse should be urged to make entries in the " State of consciousness," " pupils " and " Treatment " columns, as a change in condition may be attributable to a dose of sedative, for instance.

Drugs—Chemotherapy.

Penicillin does not readily reach the meninges and must be supplemented by a polyvalent sulfonamide such as sulfadiazine. Heavy prophylactic dosage should be the routine, bearing in mind the potential infective complications in the chest, wounds, urine and elsewhere.

Sedation.

Morphia is best avoided as it depresses respiration and cough reflexes and may lead to a harmful degree of cerebral anoxia. Paraldehyde (2 cc. intramuscularly), soluble phenobarbitone (gr. 1 intramuscularly) are valuable maintenance sedatives and initially, if a vein can be held still for a few seconds, a dose of thiopentone is a godsend for a noisy struggling patient.

OPERATIVE TREATMENT.

Lumbar puncture. A usual empirical indication is unconsciousness lasting 24 hours after a head injury. Release of raised intracranial pressure may lighten the coma or restore consciousness and if so, it may be repeated as often as seems necessary.

In other cases it may solve a diagnostic problem. For example, a fall and head injury may be the initial symptom of a stroke, a cerebral tumour, a leaking cerebral aneurysm or even a fulminating meningitis.

Subdural or extradural hæmorrhage. Occasionally the classical history or concussion followed by a "lucid interval" and then progressive deterioration suggests a tear of a middle meningeal vessel. Generally a fracture-line crossing its course can be seen in the X-ray.

More usually, with or without focal neurological signs, there is progressive deterioration with rising intracranial tension suggestive of a subdural hæmatoma which cannot be localised. In these circumstances it is customary to make bilateral burr-holes under local anæsthesia, in the frontal, temporal and parietal areas, in the hope of locating a hæmatoma which can be evacuated. In my experience, most of these cases show at autopsy diffuse traumatic cerebral œdema and no hæmatoma.

Patients with head injuries stand general anæsthesia badly and in particular, any major cerebral operation should be delayed until confusion has completely recovered, *i.e.* for several weeks.

Dehydration treatment. It used to be thought that concussional symptoms were due to raised intracranial pressure and could be helped by severe dehydration and hypertonic enemeta. As both these beliefs are generally wrong, the method has gone out.

3. THE RECOVERY PERIOD.

As consciousness returns the patient passes through a phase of confusion and disorientation, and during this the doctor must explain to him (repeatedly, for his memory is short) what has happened, and reassure him that he is getting better and will be all right and not go mad, etc.

He will also suffer from headaches and can expect them to get less frequent and pass off. Like other headaches, they tend to be brought on by intellectual and emotional strain, fatique, bright lights and noise and motion pictures. Severer head injuries may leave permanent impairment of intellect, affect and motor functions in any combination; and the effect of these residua depends on the patient's educational standard, the work he does, his previous personality and his family history.

Mental and physical rehabilitation cannot be considered separately. The urge to make a complete recovery needs a cheerful atmosphere of confidence and encouragement, for depression and despair are easily provoked. Simple decisions and exercises in judgment and behaviour are part of the ordinary ward activities and recreations. In severer cases with gross impairment, particularly after destructive brain wounds, prolonged and specialised re-education may be necessary.

Physical exercises and rehabilitation should usually start within a day or two of the accident. The patient must sit up as soon as he is conscious; sit in a chair as soon as he can do so without falling out of it; and start walking as soon as he can stand with assistance. Staying in bed does nothing but harm and it is specially harmful to spend any length of time lying flat, as this leads to headache and intense giddiness on changes of posture. For this reason, the physiotherapist starts at once with head turning

exercises, best taught in the competitive atmosphere of a class, and works through a graded course of exercises up to strenuous P.T. The rate of progress will vary from case to case and some severely affected or infirm patients obviously cannot reach the top grade.

The particular aims of this course are to restore the patient's confidence in his physique, re-educate the labyrinth and reduce headache, which is treated by the usual analgesics without interrupting the course.

The training must include all the patient's normal everyday activities, carefully assessing the time at which he is able to progress to the next stage without finding it too much for him; and before leaving hospital he should be able to go out into the noise and bustle of the streets, enjoy a cinema and so on. In most cases some explanation to his relations will help to ensure that he is neither nagged nor mollycoddled when he goes home.

The principle of treatment should be to return him without delay to nearly normal, so that on his return to an understanding home, he is not only able to lead a normal life, but eager and confident of his ability to do so.

Lectures in Brief

CARCINOMA OF THE STOMACH

By GUY BLACKBURN, M.Chir., F.R.C.S.

ANALYSIS of the deaths in two surgical wards of the hospital in the past year showed that half were due to carcinoma of the stomach. In England and Wales alone, 11,000 to 12,000 people die of this disease annually, two males for every one female. After diagnosis, a survival rate of 5 per cent. is recorded for five years, but few if any survive ten. This emphasises the importance of early diagnosis.

Considering the symptoms and signs, any form of indigestion or anorexia arising n a patient past forty years of age is most significant, as is a change in the already existent symptomatology of a patient with a known gastric ulcer. Anæmia, with complaint of fatigue, is common and particularly marked in Linitis Plastica (leather-bottle stomach) or with ulcerated growths. Pyloric obstruction, dysphagia, or the presence of a tumour in the epigastrium, must all suggest this diagnosis, while ascites, sub-acute intestinal, obstruction and jaundice almost invariably indicate inoperability.

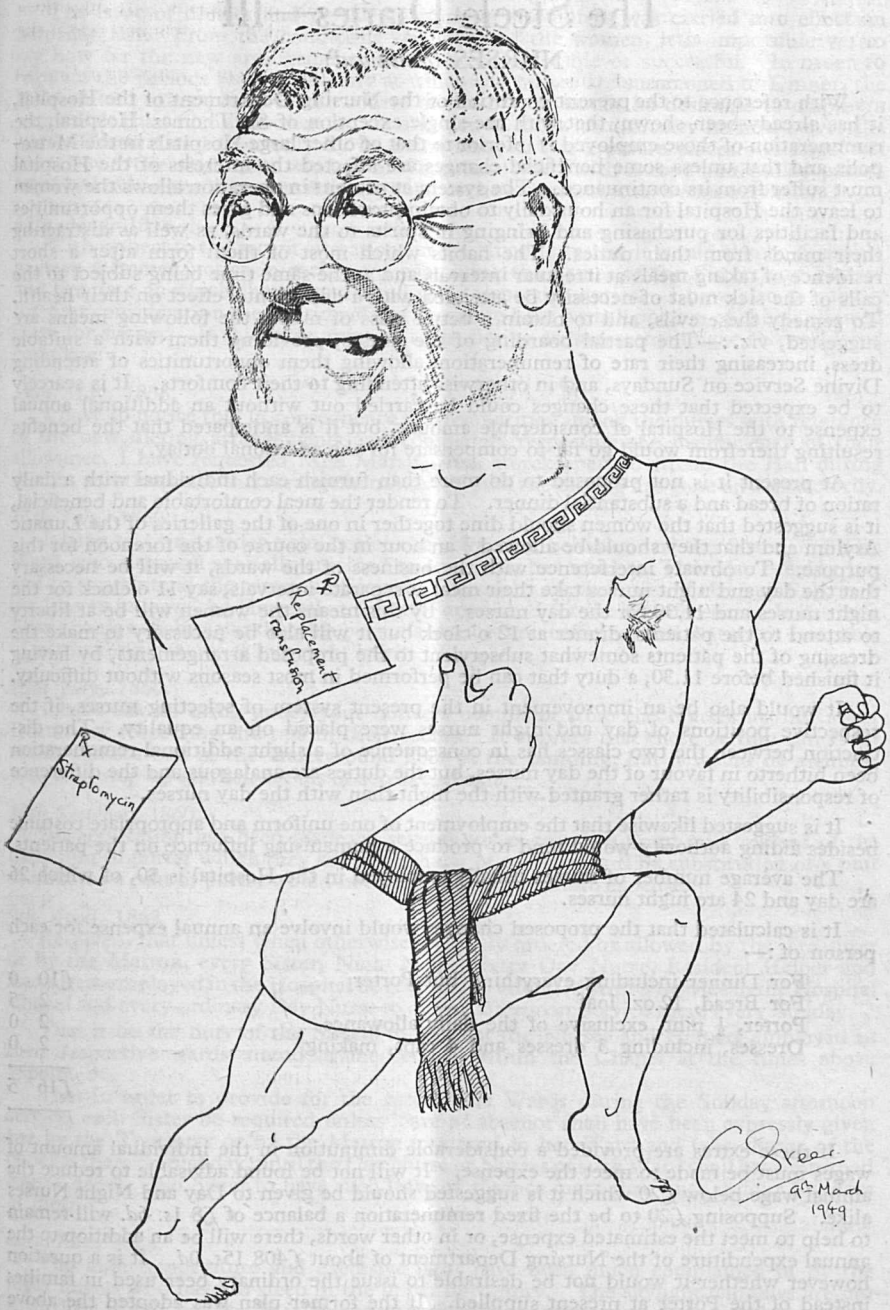
A laparotomy should be performed without hesitation in cases with equivocal X-rays or those thought to have benign ulcers not responding to treatment.

As regards the site of occurrence, roughly 50 per cent. occur in the pyloric antrum, 25 per cent. in the body and 15 per cent. in the fundus. 10 per cent. are of the leather bottle type. Malignant change in an ulcer occurs in not more than 5 per cent. of cases, and gastroscopy may be particularly helpful in identifying these. Ætiological factors worth consideration are diet, the temperature of the food, deficient mastication and bad teeth, while some races are more prone to the disease than others. 25 per cent. of the rare gastric adenomatous polypi become infiltrative, but chronic gastritis is thought to be an effect rather than a cause. The incidence of carcinoma ventriculi in patients with pernicious anæmia is probably no higher than in a normal group, but patients with the former disease tend to develop an anæmia of the Addisonian type. The ætiological significance of tobacco and alcohol is not clear. Common sites of spread are the liver, colon and local lymph glands. Rare sites which should be remembered are Wirchow's gland, the umbilicus and the ovary. Blood stream metastasis to bone occurs very late and in less than 10 per cent. of cases. The growths are for the most part spheroidal-celled. The uncommon type displaying colloid degeneration is particularly malignant.

Total gastrectomy is the only operation which offers hope of radical cure, but it carries a high operative mortality (20 per cent.). A more local excision permits of easier convalescence and a quicker return to what is left of life, and should be considered from that point of view.

Contributors are reminded that articles and notices to appear in the *Gazette* must reach the office in St. Thomas's Street **by noon on the Monday prior to publication.** Only matters of extreme urgency can be accepted any later and approach should then be made direct to the Editor or Manager.

AND SO VICTORIA!



"Remember, *three* things—urea clearance, gum saline and Morris dancing to gramophone records!"

The Steele Diaries—III

NURSES (*continued*)

With reference to the present condition of the Nursing Department of the Hospital, it has already been shown, that with the single exception of St. Thomas' Hospital, the remuneration of those employed is inferior to that of other large Hospitals in the Metropolis and that unless some beneficial changes are affected the interests of the Hospital must suffer from its continuance. The system at present in operation allows the women to leave the Hospital for an hour daily to obtain provisions and gives them opportunities and facilities for purchasing and bringing in spirits to the wards, as well as distracting their minds from their duties. The habits which most of them form after a short residence of taking meals at irregular intervals and at the same time being subject to the calls of the sick must of necessity be attended with a detrimental effect on their health. To remedy these evils, and to obtain a better class of nurses the following means are suggested, viz. :—The partial boarding of the nurses, providing them with a suitable dress, increasing their rate of remuneration, allowing them opportunities of attending Divine Service on Sundays, and in otherwise attending to their comforts. It is scarcely to be expected that these changes could be carried out without an additional annual expense to the Hospital of considerable amount, but it is anticipated that the benefits resulting therefrom would go far to compensate for the additional outlay.

At present it is not proposed to do more than furnish each individual with a daily ration of bread and a substantial dinner. To render the meal comfortable and beneficial, it is suggested that the women should dine together in one of the galleries of the Lunatic Asylum and that they should be allowed ½ an hour in the course of the forenoon for this purpose. To obviate interference with the business of the wards, it will be necessary that the day and night nurses take their meal at separate intervals, say 11 o'clock for the night nurses and 11.30 for the day nurses. By this means the women will be at liberty to attend to the patients' dinner at 12 o'clock but it will also be necessary to make the dressing of the patients somewhat subservient to the proposed arrangements, by having it finished before 11.30, a duty that can be performed in most seasons without difficulty.

It would also be an improvement in the present system of selecting nurses, if the respective positions of day and night nurses were placed on an equality. The distinction between the two classes has in consequence of a slight additional remuneration been hitherto in favour of the day nurses, but the duties are analagous and the difference of responsibility is rather granted with the night than with the day nurses.

It is suggested likewise that the employment of one uniform and appropriate costume besides aiding authority would tend to produce a humanising influence on the patients.

The average number of nurses usually employed in the Hospital is 50, of which 26 are day and 24 are night nurses.

It is calculated that the proposed changes would involve an annual expense for each person of :—

For Dinner including everything but Porter	£10 0
For Bread, 12 oz. loaf	2 5
Porter, ½ pint, exclusive of the daily allowance	2 0
Dresses, including 3 dresses and 4 caps, making	2 0
	£16 5

If these extras are provided a considerable diminution in the individual amount of wages must be made to meet the expense. It will not be found advisable to reduce the annual wage below £20 which it is suggested should be given to Day and Night Nurses alike. Supposing £20 to be the fixed remuneration a balance of £8 1*s*. 6*d*. will remain to help to meet the estimated expense, or in other words, there will be an addition to the annual expenditure of the Nursing Department of about £408 15*s*. 0*d*. It is a question however whether it would not be desirable to issue the ordinary beer used in families instead of the Porter at present supplied. If the former plan was adopted the above sum could be reduced by not less than £100. The expense of these alterations may appear large, but it is also to be presumed that they may to a large extent be diminished by an anticipated reduction in the amount of diets issued to the patients.

5th May, 1858.

The issue of dresses and partial boarding of the nurses was carried into effect on Saturday last. From the conflicting testimony of the women, it is impossible yet to say how far the new arrangements have proved agreeable or successful. In order to regulate the periods more uniformly at which the nurses are summoned to Dinner, the Kitchen and other places in the course of the day, it would be desirable to employ a larger Bell than that at present in use and which can with difficulty be heard over the whole Hospital and then only by its being rung in two separate places. A large bell placed over the washroom window of Cornelius Ward with a rope and pulley passed into the kitchen could be conveniently rung at the stated intervals by the servants.

12th May, 1858.

With respect to the recent alterations in the Nursing system it would also be desirable to have a framed notice in each ward containing the names of the Sisters and Nurses and the date at which they commenced their respective duties. I have also to submit for your consideration the petition of the Nurses to have a small portion of cheese allowed them for supper. If this were granted, their dieting arrangements might be considered complete.

19th May, 1858.

I have to notice that in consequence of irregularities among the nurses with reference to the new dieting arrangements and complaints respecting the insufficiency of their allowance, I have requested Miss Marsh, linen storekeeper, to attend the Hall during dinner, and that since this arrangement was adopted the dieting has gone on satisfactorily.

11th July, 1860.

I have to bring under your notice the refractory behaviour of the Sister of Philip Ward who although specially enjoined to remain in her ward on Thursday evening last and to superintend the removal of several patients to another part of the building, took the liberty to leave the Hospital at the time appointed for the transference. It has long been a cause of complaint that this person's services are inefficient and that she is incapable of performing her duties in a right spirit.

25th July, 1860.

I have also to bring under your notice a complaint from the Nurses in the Lower Dormitory respecting the rats in their rooms. It appears that these vermin can roam about undisturbed in the underground floor of the building, but it would be a simple matter to stop up all their means of access and exit.

10th October, 1860.

An application has been made by several nurses to allow them milk instead of the daily pint of porter which they are in the habit of receiving. The substitution of a pint of milk for a pint of porter would not be attended with more expense.

9th April, 1862.

Resolved, that unless when otherwise expressly ordered or allowed by the Treasurer or by the Matron, every Sister, Night Nurse, Extra Day Nurse, Resident Helper and Laundress employed in the Hospital be required to attend Morning Service in the Hospital Chapel and every ordinary Day Nurse to attend afternoon Service there every Sunday.

That it be the duty of the Sisters to see that the Nurses and Helpers employed in their respective wards attend divine service within the Chapel at the times above appointed.

That in order to provide for the care of the Wards during the Sunday afternoon service, each Sister be required unless leave of absence shall have been expressly given her by the Treasurer or by the Matron to attend in her Ward and take charge of the patients there on that day, until the Day Nurse or Nurses of such Ward shall have returned from Chapel. No Sister to have such leave of absence more than once in four Sundays at most.

29th July, 1868.

The high temperature and excessive light have been much complained of by the night nurses who have to sleep in the upper dormitory. The skylight windows are not shaded by blinds nor would it be very practicable to make them open and shut. Considerable relief has been afforded by placing serge counterpanes over the skylights but it would be a greater improvement to make the ordinary windows of the dormitory which are flush with the wall open and close readily from the outside.

18*th November*, 1868.

Great commotion was caused in Luke Ward on Saturday in consequence of the disappearance of the day nurse from the ward and the discovery that a portion of the wearing apparel of twelve of the patients had been taken from the ward. The clothes had been pledged by the nurse assisted by one accomplice at least, a woman who has been for several years a scrubber in the Hospital, and a greater portion of them have been restored to their owners. Several articles are however still missing and the police are making inquiries respecting them.

30*th December*, 1868.

The nurse lately attached to Esther Ward caused considerable excitement on Monday afternoon by swallowing with intent to injure herself a considerable quantity of white precipitate of mercury. She had previously had some misunderstanding with the Sister of Martha Ward.

15*th May*, 1869.

Jane Harris—day nurse of Luke Ward—was summarily dismissed on Monday last for insubordination and inattention to her duties.

1*st December*, 1869.

An application has been made to the Hospital by several medical men and others in Wales to obtain the loan and assistance of 4 experienced nurses to wait for a time on the person known as the "Welsh fasting girl," the applicants paying all expenses. Sister Naaman with two nurses have been selected as willing to undertake the duty, and it is proposed that they should leave for the purpose in the course of next week.

18*th January*, 1871.

The Sister of Lazarus Ward, having become unfitted for her work through intemperance, has been superseded for the present by one of the probationary Sisters.

28*th May*, 1873.

Two cases of Mental Aberration arising from injuries to the head are at present in the strong room. Some danger was apprehended on Saturday last in consequence of one of the patients leaving his bed and threatening to injure the nurse with a poker. Notwithstanding the screams of the nurse she failed to make anyone aware of the extent of her danger. It might be advisable to have a bell or speaking tube from the Strong Room to Accident Ward to procure additional assistance if it should be wanted in emergency.

2*nd July*, 1873.

A mistake which was likely to produce serious consequence occurred in Job Ward last Thursday night from the Sister administering Carbolic acid lotion instead of Quinine Mixture to two patients in succession. The misadventure arose from the substitution of one bottle for another, the label of the carbolic acid bottle having fallen off from the cork to which it had been attached.

29*th December*, 1875.

Dr. Moxon complains that the Sister of Philip Ward is unfitted for the numerous duties required from a Sister of a large ward, that she has shown discourtesy to himself and to friends of his own who have visited the ward, and that she is wanting in the knowledge of the requirements of the patients.

A complaint was made by the friends of a deceased patient yesterday to the coroner that the night nurse of Charity Ward had behaved unkindly to the deceased. There seemed to be no ground for the complaint further than the statement of the deceased.

31*st May*, 1876.

It having come to my knowledge through the police, that a woman in their custody has several articles in her possession belonging to Mary Ward, the Sister of the ward appeared against her in the police court yesterday and recovered 3 blankets, a couple of counterpanes along with some pillow cases, and spoons marked with the Hospital letters. The prisoner had previously been a nurse in Mary Ward and held a good character while in the Hospital.

29*th August*, 1877.

I have to report the case of the night nurse of Luke Ward who was confined of a child in the night Nurses' dormitory last Saturday morning. She had been in the service of the Hospital about 12 months.

22*nd May*, 1878.

Maria Grant, a nurse probationer from Job Ward, absconded from the Hospital on Thursday last with money to the amount of 27 shillings belonging to 3 of the patients.

She was apprehended on Monday and was found to have pawned one of the Hospital dresses which has been ordered by the magistrate to be delivered up.

1st January, 1879.

Wednesday being Christmas Day the patients were furnished with the usual Christmas fare of roast beef and pudding—a party of students numbering from 25 to 30 visited the several wards in the course of the afternoon and by their boisterous conduct caused great disturbance and commotion among patients and nurses. Much of this could have been avoided had proper action been taken on the part of many of the Sisters to discountenance the riotous proceedings. Mrs. Burness the Sister of Lazarus Ward who was partly instrumental in causing much of the noise has been discharged from her office by the Treasurer.

22nd October, 1879.

At an inquest held at the Hospital last Wednesday it transpired that a nurse had received a shilling from the Mother of a deceased patient and the Jury in consequence (in addition to their verdict of " Accidental death ") added an expression of opinion that the system of feeing nurses should be brought under the notice of the Governors. In accordance with the regulations the nurse has since been dismissed from the Hospital service.

Obituary

Sir WILLIAM HALE-WHITE, K.B.E., M.D., LL.D., F.R.C.P.

SIR WILLIAM HALE-WHITE, who died at his Oxford home on February 26th at the age of 91 years, was well-known as a clinician, teacher and author of a famous book.

He entered Guy's Medical School in 1875, and so began his long association with the Hospital. He qualified in 1879 with honours and gained his M.D. the following year. In 1881 he became demonstrator in anatomy at Guy's, a position which he held until 1885 when he was appointed an assistant physician. He also took over the lectureship in materia medica, pharmacology and therapeutics and in 1899 became a lecturer in medicine.

By this time his renowned work on " Materia Medica, Pharmacy, Pharmacology and Therapeutics " had appeared and still it is in great demand to-day. In 1901 Hale-White edited a more elaborate volume, " Textbook of Pharmacology and Therapeutics," and 1908 saw his book " Common Affections of the Liver " which embodied his considerable experience on the subject both as clinician and teacher. He was also joint editor of " Guy's Hospital Reports " from 1886–1893 and in 1925 founded the " Postgraduate Medical Journal of the Fellowship of Medicine " over which he presided for five years.

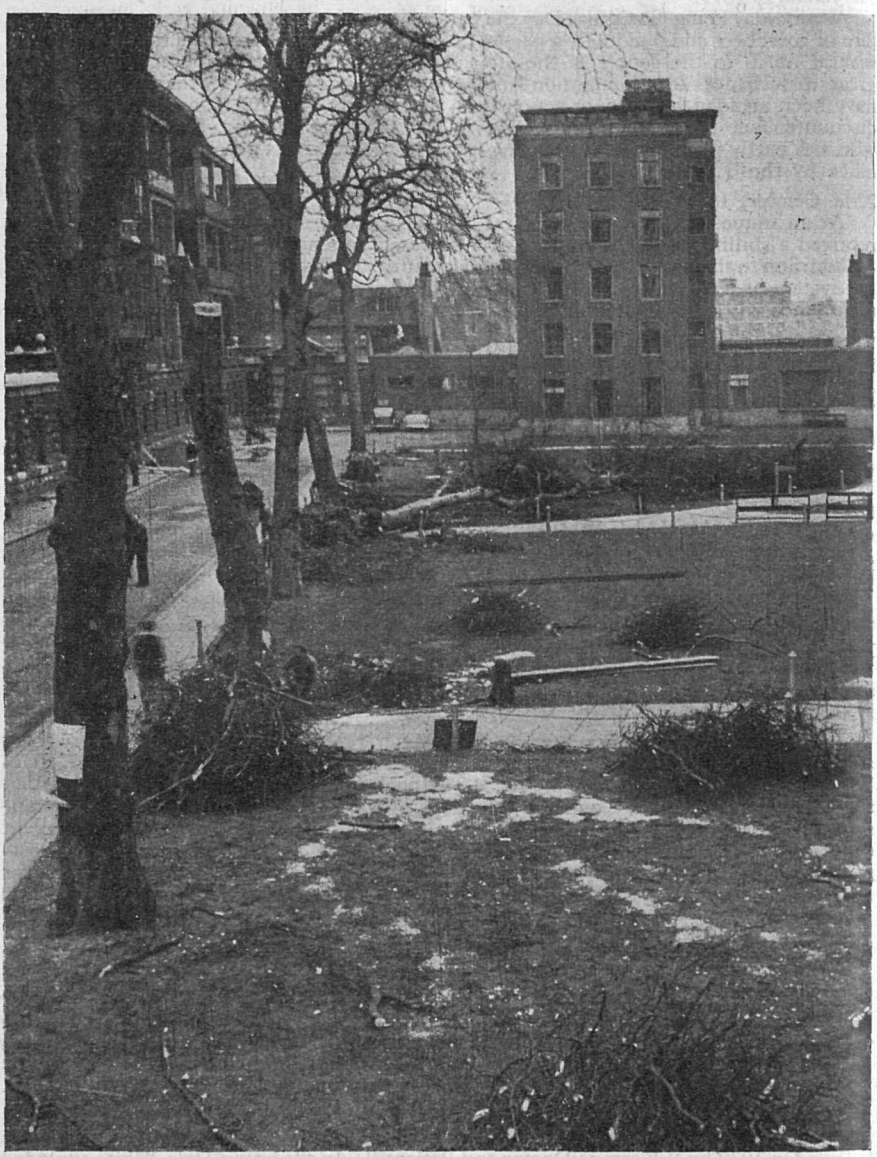
Hale-White was elected F.R.C.P. in 1888 and served the College as examiner, councillor and censor. In 1897 he delivered the Croonian Lectures on the means by which the temperature of the body is maintained in health and disease, and his Harveian oration in 1927 on " Bacon, Gilbert and Harvey " reflected his interest in medical history.

During the 1914–18 War, Hale-White, besides being a brevet-colonel, consulting physician to many war Hospitals and a member of the Final Medical Appeal Board, was also chairman of Queen Mary's Royal Naval Hospital, Southend. After twenty-nine years as physician to Guy's Hospital, he retired in 1919 and became a consulting physician. The same year he was created K.B.E.

In 1935 his " Great Doctors of the Nineteenth Century " was published, which was followed in 1938 by " Keats as Doctor and Patient." In the latter, Hale-White exploded many false assumptions about Keats and concluded that " all we know is that Keats was attacked by reviewers and died of consumption."

Hale-White wrote many papers and, apart from his general influence, his writings on perihepatitis and on the distinction between hæmatemesis from acute and from chronic ulcer have passed most completely into general knowledge.

He married in 1886 Miss Edith Fripp, sister of his colleague Sir Alfred Fripp. She died in 1945. They are survived by one of their sons, Dr. Reginald Hale-White.



Photograph by Patricia Turnbull

THE PARK—17th MARCH, 1949
FELLING IN PROGRESS

"Things that go Bump in the Night"

A totally unexpected crash shattering the calm of the Hospital early one morning last week caused some concern among those within the precincts until the discovery was made that two trees lay fallen in the Park where only one had lain previously. The fact was that no time had been lost by the Works Department in acting upon the advice of the Curator of Kew Gardens regarding the familiar Planes, upon which subject a letter appeared above the signature of the Superintendent in the issue of the *Gazette* dated 26th February. A gang of expert fellers quickly took command of the sylviculture and proceeded with masterful precision to deal summarily with the condemned trees, attacking them root and branch. Their efforts held the attention of an appreciative audience practically throughout the day.

It was one impatient Plane that, having been more or less mortally mutilated by the blows from the woodmen and left overnight, apparently decided to put an end to itself without further ado. Hence the crash. No harm, fortunately, was done.

Next day the spoiling went on with renewed vigour. By the aid of a most astonishing mechanical saw, its note resembling that of a German "buzz-bomb," the fallen timber was rapidly reduced to a heap of tidy logs. And so it was cleared away.

Plane wood, according to the countrymen, is quite useless for any structural work and is equally disappointing as fuel. To a limited extent it finds a use for inlay work. No memorial relic of the trees that have shaded the Park for so long is therefore likely to be preserved. Instead, consolation must be derived from the thought that already measures are in hand for the planting of ornamental shrubs, once again by the suggestion of the Kew Gardens authorities, in the prominent gaps now revealed.

Candid Comment

IN choosing for their latest production Shaw's *Candida* the Theatre Club showed admirable taste and great courage—it is not an easy play for amateurs. Past productions by this Club have been of a very high standard and it would seem unfair simply to state that the present production does not reach the former level unless some sort of comprehensive analysis is also given. In what respect does this production fall from grace? Certainly not because of stage settings and furniture, which were all admirably conceived and executed, and contrived to give the authentic period atmosphere. The lighting, too, was much more than "just adequate." But it was the portrayal of the characters themselves which was not always quite convincing. *Candida* contains very little action and therefore relies for its success even more than most plays on the faithful representation of the emotional conflict between the poet, the clergyman and his wife—all idealists in their own different ways. Unfortunately, this production failed at times to bring out the subtleties of character in the leading parts. This is said advisedly, as "Prossy" was a brilliant exception, giving as she did a complete character sketch of the adoring secretary. The main difficulty seemed to be one of production. This is definitely not a play where the modern fashion for under-acting in the Coward style is to be recommended and it lost much of its character and force through having some of its emotional scenes recited in the manner of a news bulletin. Another small though important fault lay with members of the cast who did not wait for their laughs—many good lines were lost on this account.

On the credit side it must be said that most of the entrances and exits were excellently timed and that generally speaking the grouping was good and the players moved about the stage with a natural ease.

That criticism is easy is fully appreciated. Only a fellow producer knows the difficulties that have to be overcome before a play can go on at all.

It is hoped that the foregoing remarks, coming as they do from a completely unbiased and impartial observer, may spur the members of the Club on to reach once again the almost professional standard which has been achieved in the past.

M.F.

At all six performances of *Candida* rendered by the Theatre Club very large and appreciative audiences were present. More than twelve hundred people are estimated to have seen the show during the course of the week. A very respectable financial margin is likely and this money will be handed over shortly to the Caleb-Diplock Fund for the children.

A Case of Chronic Subdural Hæmatoma

By DAVID ELLIS, M.B., B.S.

Mr. S., aet. 60, was admitted to the High Wycombe and District War Memorial Hospital on 14th November, 1948, as an emergency. He had been in good health until 15 days before when he returned from a day's shooting complaining of a severe headache and he vomited several times. Persistence of headache led him to consult his doctor two days later at which time there were no neurological abnormalities, nor indeed any satisfactory explanation for the headache, which was unrelieved by rest in bed, aspirin or ergotamine tartrate.

On the ninth day of his illness he became drowsy and very unsteady on his legs, tending to fall backwards. He was seen by Sir Charles Symonds who found him somewhat confused, but he was alert and co-operative although a few hours earlier it had been impossible to rouse him. The only positive neurological abnormalities were a slight relative increase in the tendon reflexes in the right arm, the left plantar response was absent and the right flexor. The relatives now remembered that the past year or two the patient had frequently complained of a severe pain in his head when he coughed. Sir Charles Symonds formed the opinion that there was a space-occupying lesion, possibly a tumour of the 3rd or 4th ventricle, and arranged to admit him to hospital for further investigation as soon as there was a vacancy.

For the next five days he was much better, but there were considerable variations in his state of consciousness, *i.e.* at times he was very drowsy and at other times quite alert. Repeated examination revealed no new neurological developments and in particular there was no papillœdema.

On the day of admission to hospital, he was very drowsy in the morning and became more deeply unconscious as the day wore on. By the evening he was entirely unresponsive, incontinent, and respiration was irregular with intervals of apnœa lasting up to 30 seconds. Both plantar responses were now extensor. He was removed to the High Wycombe and District War Memorial Hospital where he was examined by Sir Charles Symonds and Mr. Pennybacker who considered the alternatives of acute hydrocephalus and subdural hæmatoma. At operation Mr. Pennybacker discovered a large subdural hæmatoma in the left fronto-parietal region, and this was aspirated and cleared by irrigation through four burrholes. There was no hæmatoma on the right side. The patient had become fully conscious before leaving the operating theatre but relapsed into unconsciousness six hours later. After a further aspiration and irrigation full consciousness was again restored and there were no further relapses.

After the second operation, it was observed that he had bilateral ptosis and defective upward movement of the eyes. These signs cleared up within two or three days.

When the patient regained normality he remembered that about six weeks before the onset of his illness he had tripped in his office and struck his head against a door. He was dazed for a moment, and for some days afterwards had a pain in his head, but it cleared up and he thought nothing of it. Such a trivial injury is a common cause of subdural hæmatoma in elderly subjects, and the variable drowsiness observed in this case is often an outstanding feature. Although gross neurological abnormalities, *e.g.* hemiplegia, aphasia, hemianopia are uncommon, bilateral ptosis (giving a sleepy appearance even when the patient is mentally alert) and defective upward movement of the eyeballs frequently occur, and should raise the possibility of a lesion which is eminently curable by a simple surgical procedure.

At the first Surgical Staff Conference reference was made more than once to the "cardiac organ." This, we learn on good authority, is not to be regarded as a precedent.

Such is the degree of refinement which patients ascribe to the medical profession and its drugs of choice that a pharmacist complains of a customer the other day asking for some "Gentile Violet."

The naming of a house presents difficulties almost as great as the naming of a racehorse. In one instance, at least, the consequences appeared tragic. A patient admitted to an obstetric ward in one of the sector hospitals gave a history of eight miscarriages. From her record papers the address read—"The Labour-in-Vain."

Satura in Henricum Vertutem

" Insani sapiens nomen ferat, æquus iniqui,
Ultra quam satis est Vertutem si petat ipsum."

" He earns the name of fool, though just and wise,
Who seeks more Vertue than his need supplies."

Muse, who of old once guided Pope's high rage
To lash the faults and vices of his age,
And warmed the chalice of great Dryden's ire
With satire's bitter, uncelestial fire;
You, who inspired the smooth and polished pen
Of Juvenal to scorn the ways of men,
Assist me now. Of him, destined at Guy's
To be the last great master of the wise
I sing, that lesser minds may learn in fear.
They are but fools who only stand and jeer.

In these dark days when Learning's lamp is dim,
He comes with beetling brow and mellow voice
To teach the truths that once made all the world rejoice.
Tho' to assist his apostolic zeal
He brings great learning (but no sex-appeal)
And uses knowledge of old pagan days
To supplement his arguments 'gainst stays.
So answers, if the moderns 'gin to shudder:
" You made the sterile teat—God made the udder."
And if in lecture-hall he goes to speak
He sometimes uses Latin, sometimes Greek;
By the untutored oft his praise is sung
Who heard him once employ the English tongue,
For, pondering o'er the problem of a belly,
He diagnosed: " Diathesis of Shelley."
Now we, of modern age, find it quite thrillin'
To understand the ways of Penicillin,
Yet he reminds us of another kind
Who used, not hypodermics, but the Mind;
Though in the nurses' hearts he could not win
A place, for he withheld the Aspirin,
But soothed their brows bedewed with sweat all briny,
By reading them quotations out of Pliny.

But now, if a warped humour or disdain
Hath marred the hues that you have lately read
And stirred my jealousy to vail again
At those dim heights that I may not attain,
Pardon the hand that wrote them, for I dread
That though this gentle satire I should rend
You would think ill of it, and cease to be my friend.

B.D.J.

Rugger—The Inter-Hospitals' Cup

After the protracted semi-finals against Middlesex, which eventually culminated at H.O.P. in a win for Guy's by 9 points to 6, there was eager anticipation for the final against St. Mary's. This took place at Richmond on Wednesday, 23rd March.

In a thrilling match fought at a hard pace throughout, Guy's were beaten 5—6. Mary's opened the scoring by a try, the result of a beautiful passing movement along the line. Eight minutes from the end Guy's pressed hard and, after the ball had travelled from man to man down the wing, Gray hurled himself over. Le Clus converted to put Guy's in the lead. The pace then increased until Beatson, from a penalty on the 25-yard line, kicked the ball a couple of yards, caught it and, running at top speed, threw himself over to score the winning try.

It was a disappointing end to a keenly fought match.

Reviews

Clinical Chemistry in Practical Medicine. By C. P. STEWART and D. M. DUNLOP. 3rd Edn. Livingstone. *Price* 17*s.* 6*d.*

LABORATORY aids in clinical medicine are still regarded with scepticism by practising clinicians. Yet in diagnosis, prognosis and treatment they can afford valuable guidance. In this very readable book, compiled jointly by a chemist and physician of the Edinburgh School, a clear and at times perhaps over-simplified explanation is given of the physiological and pathological principles underlying most of the recognised laboratory investigations. Practical directions appear in the appendix.

Enthusiasm for laboratory results is restrained, even in this work. The vagaries and limitations of the various tests are emphasised and their place in clinical practice is put into proper perspective.

G.

Treatment by Manipulation in General and Consulting Practice. By A. G. TIMBRELL-FISHER. 5th Edn. Lewis. *Price* 25*s.*

THIS book is a comprehensive account of manipulative surgery, each joint is considered separately, firstly the anatomy and normal range of movement, then the technique of manipulation.

There are excellent chapters on the pathology of formation of adhesions, on their prevention and on their diagnosis.

Throughout the book stress is laid on the limitations of manipulative surgery and of the dangers of manipulation in unsuitable cases.

This book, not suitable for undergraduates, is an essential part of the library of anyone who may undertake manipulative surgery.

B.G.A.L.

Failure of the Heart and Circulation. By TERENCE EAST. 2nd Edn. Staples. *Price* 8*s.* 6*d.*

WHEN this monograph was first published more than ten years ago its purpose was to explain the principles underlying those changes in the body which lead ultimately to the condition of heart failure. By such knowledge, it was claimed, earlier and better diagnosis would be possible and more efficient treatment could be instituted. Progress in this subject over the succeeding years has led to a re-assessment of many of the old ideas. In this second edition the original purpose remains and a most lucid account is given of current theories and practices based on recent conceptions. The reader, however, must have a thorough understanding or, better still, a wide experience of the clinical problems if he is to assimilate the teaching therein. The book, therefore, is one for the practitioner rather than the student, unless of course the student has a particular flair for hearts.

G.

Brompton Hospital Reports. Vol. XVI, 1947. Published by, and obtainable from, that Hospital. *Price* 10*s.*

BEAUTIFULLY bound, printed and presented, with many illustrations, this volume contains articles on Constrictive Pericarditis (by A. Tudor Edwards and D. Barlow), Superior Vena Caval Obstruction (by O. S. Tubbs), Bronchiectasis and Atelectasis (by F. P. Lee Lander), The Treatment of Pulmonary Hydatid Disease (by N. R. Barrett), and several others. No further commendation of authenticity is required than the name of the hospital from which the report comes.

Operative Dental Surgery. By J. B. PARFITT and W. E. HERBERT. 6th Edn. Arnold. *Price* 30*s.*

IN pursuing their intention "to present a coherent body of technical methods of proved clinical value," the 'Authors' have brought this most valuable guide to an understanding and practice of Dentistry, completely up-to-date.

The "whole-mouth" and conservative approach is most fully developed, in the protection of the vital pulp, the conservation of tooth structure, the desirability or otherwise of inserting a bridge.

Perhaps the most interesting chapter, discussing the treatment of pulpless teeth, gives a clear picture of the best modern teaching, as does the whole of this most excellent and stimulating little volume.

R.D.P.

Dental Practice Management. By S. L. DRUMMOND JACKSON. 1st Edn. Staples. *Price* 30*s.*

MANY books on the subject use many words and yet leave the reader with little more than nebulous ideas. Mr. Jackson is never vague and his fearless approach to many difficult aspects, such as money and personnel management is admirable. It is too much to expect that any one practitioner should be able to combine all the virtues and knowledge advocated but no practitioner on the other hand will fail to find much that is valuable.

A nice balance is achieved between the patients' and the dentist's interests and were it not that patients would come to expect too much from us much good would come from their reading the book also.

No words are wasted and it is difficult to think of any important omissions. The absence of a humorous background will be appreciated by many, especially as the book is almost a work of reference.

There is no mention of the complexities of the National Health Service as the book was published before it came into effect.

In an effort to find fault in an excellent book one can only regret that there is no discussion of the modern card indexing systems or book keeping.

The newly qualified about to commence any form of Private Practice will be well advised to practice many of the things Mr. Jackson advises.

A.T.

An Introduction to Public Health. By E. W. CARYL THOMAS. 1st Edn. Wright. *Price* 15*s.*

THE subject of public health has little attraction for the average student. It figures separately in most qualifying examinations and consequently demands some attention. The popular text for the undergraduate is condensed to render the essential facts in the smallest space. But apart from the examination, public health should and, in fact, does concern every medical man. The fault, perhaps, is to regard it as a separate subject at all. A more readable work, making the study more vital and putting it into proper relationship with the more clinical aspects would "fill a long-felt want." The work under review contains all the essential facts for the undergraduate. Unfortunately, although more up-to-date, it is scarcely more absorbing or illuminating than what is already available.

G.

Bilharzial Cancer, Radiological Diagnosis and Treatment. By M. A. AFIFI. Lewis. *Price* 16*s.*

THIS monograph is composed on twenty-five years experience in Egypt, where bilharzia of the bladder is a very frequent occurrence. The term "bilharzial cancer" has arisen on account of the fact that it is often associated with or predisposes to bladder carcinoma. As this disease is not encountered in London, the findings are interesting. In plain radiograms the calcified ova may show up the bladder wall or the lower end of the ureter; the bilharzial carcinoma of the bladder shows up in a cystogram as a filling defect.

In intestinal bilharziasis the radiological diagnosis is not clear cut, nor is the association with carcinoma nearly as marked.

The bladder lesion occupies most of the section on treatment. In the fully established carcinoma in these subjects the prognosis is exceedingly gloomy; about 50 per cent. of patients are inoperable when first seen and the response to surgery, radium or deep X-ray therapy appears to be very poor.

F.J.K.

Anæsthesia for the Poor Risk. By WILLIAM W. MUSHIN. Blackwell Scientific Publications. *Price* 7*s.* 6*d.*

THIS is neither a text-book nor a monograph on anæsthesia for the poor risk, but a collection of essays which are closely or remotely connected with anæsthesia for this type of patient. The essays are rich in both thought-provoking and controversial matter. In his preface the author says that the contents of his book are the result of enjoyable and fruitful discussion, and that he hopes that it will produce equally valuable discussion amongst fellow anæsthetists and their students. It will certainly provoke criticism.

D.M.C.

The Diagnosis of the Acute Abdomen in Rhyme. By ZETA. 2nd Edn. Lewis. *Price* 6*s.*

WHEN you are all tucked up in bed
There's many things you might do worse
Than read—and get into your head—
A line or two of Zeta's splendid verse.

Then you will know what Zeta knows,
—Symptoms, signs and clever stories—
Of all the common ills and woes
Found twixt midrift and the Levatores.

You'll find him different from Keats and Shelley,
But what a lot he knows about the belly.

IPMA.

Guy's Diary

MARCH—APRIL

ACADEMIC

March

Exhibition. Surgical Dept. "Twenty Questions".

28th. Exhibition. Gordon Museum. "Congenital Heart Disease."

1.00. Dr. McConnell. Clinical Lecture. "Anæsthesia for Infants and Young Children."

3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

5.00. Mr. O. G. Morgan. Dept. of Child Health. Postgraduate Lecture. "Squint in Childhood." Preclinical Classroom.

29th. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.

31st. 4.30. X-Ray Meeting. Gordon Museum.

April.

Exhibition. Surgical Dept. "Osteomyelitis."

1st. 2.15. Medical Dept. Combined Round. Preclinical Classroom.

4th. 12.00. Surgical Dept. Staff Conference. Clinical Theatre.

3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

4th. 5.00. Dr. P. R. Evans. Dept. of Child Health. Postgraduate Lecture. "Umbilical and Inguinal Hernia in Infancy." Preclinical Classroom.

5th. 1.00. Mr. Doherty. Clinical Lecture. "Prostatic Obstruction."

7th. 4.30. X-Ray Meeting. Gordon Museum.

8th. 1.00. Dr. Boland. Clinical Lecture.

9th. 10.00. Professor Pannett, St. Mary's Hospital. Surgical Departmental Round. Clinical Theatre.

11th. 3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

5.00. Dept. of Child Health. Postgraduate Lecture. Preclinical Classroom.

SPORT

March

30th. 3.15. Association Football. Hospital Cup Final. Guy's *v.* St. Mary's (Mitcham).

April

2nd. Rugby XV *v.* Richmond (Richmond).

Hockey 1st XI *v.* Westcliff (H.O.P.).

Hockey 2nd XI *v.* Westcliff (Away).

Hockey 3rd XI *v.* Westcliff (Away).

Correspondence

In Defence of Dogma

SIR,—We have been treated again to another masterly dissertation by a scholar. He is concerned this time, not only with the language of the ancients and their metaphysics, but also a practical problem—the management of early infancy.

If we can for a moment force ourselves to disregard the literary qualities of this work and confine our attention to its medical aspect, then the substance of the argument is this—to rear a healthy and happy infant one must not follow rules, but treat every infant according to the circumstances of the case.

Few masters of their art will disagree with such a proposition, because they find it to be true in their experience. It has, however, a grave weakness for the novice.

The learned gentleman is able to advise and act in all the varied circumstances which may be encountered in infant welfare with a surety developed only after many years of study.

Not so his pupils. We are ignorant and while we learn we must obey established principles, or else we never progress. In thinking, we must be objective while he can be intuitive. In judging, we must be universal while he can be particular.

The wisdom necessary to give the right advice for the specific circumstances can only be developed in the first place by being dogmatic, and by being sometimes proved wrong. It is then and then only that we come to understand when the general rule must be broken. To suggest to the student that the criteria of truth is to obtain pleasure is misleading indeed, and to support this contention by invoking the Epicurean Philosophy is unfortunate.

Whatever Epicureus meant his philosophy to be, it developed into a thorough-going, sensuous materialism where the pleasure of the moment took precedence over all else. The pleasures of Lucretius are not those of the contented mother with her child. In the latter there is always hope for the future as well as happiness of the present; in the former there is no future.

There can be no doubt that we have enjoyed reading "Pleasure at the Helm." Some will have admired the writer's style, his kindly benign humour or his profound knowledge of the classics. If these attributes have obliterated by their brilliance the method suggested by which we should approach medicine, then to criticise further would be unkind.

Yours, etc.,

GEOFFREY T. HAMMOND.

Guy's Hospital, S.E.1.

The Preclinical Course

SIR,—With reference to the content of Passim in the *Gazette* of 26th February, where you suggest a shortening of the preclinical course, I can but express my hearty disagreement. The course, as it stands, is already confined to the general principles, which are the foundations upon which clinical work should be placed. The very manœuvres, arousing so much impatience in your early studies, such as the frog jerks, pins and lenses, etc., are designed, not to torture, but to impress one with principles to be carried throughout clinical practice. They are not to be carried to the examination hall and thereafter forgotten. It is not expected of us to remember every item of preclinical study, irrespective of its worth, but that facts should stand in varying degrees of perspective in our minds as they become emphasised or modified by the further knowledge we acquire. *That* is integrated study on the broad basis of a university education, but please let us not begin our career in the skimped, utility fashion of this age, only in later days to have our knowledge boosted here—by a course of applied physiology, expanded there—by a refresher course in yet something else, to add further to the already exasperating array of lectures which haunt the clinical student of to-day. The stimulus to recall and revise forgotten work comes much more from a case in the wards than a voice in a clinical lecture.

Yours, etc.,

D. G. E. ALLDRIDGE.

Guy's Hospital, S.E.1.

The " Spit "

SIR,—Complaining comes easily to most people—far more so than helpful criticism and among the popular objects of dissatisfaction, at any rate in this country, food is probably pre-eminent. Within the home, domestic restraint precludes outright denouncement; no such restrictions apply where public catering is concerned. That is perhaps why no apology is made for raising yet again the perennial controversy about feeding arrangements in the College and, more especially, in the " Spit."

The provision, nearly two years ago, of the additional cafeteria service was welcomed on all sides and over the succeeding months the meals so served have been, on the whole, of reasonable standard and the charges by no means excessive. Lapses from quality have been obvious from time to time but under present-day conditions of supply these are forgivable. All credit to the chef and his staff for what they have achieved. Those given to grumbling about the tariff should try catering for themselves. Taking all costs into account feeding is an expensive business. If better value is really offered elsewhere then the choice for the malcontents is obvious.

Certain features, however, still give cause for concern. The atmosphere of the place, for instance, is anything but congenial; rather does it resemble that of a " public-bath or wash-house." The style of decoration has already given rise to heated argument. If, as Derek Patmore insists, good taste in such matters is largely a question of what is " appropriate " then is the prevailing and admittedly ingenious scheme of decoration presented by the " Spit " really to be approved? Evidently no experienced, commercial restauranteur would think so. Before long, refurbishing will become necessary. When colours have to be chosen cannot the warm yellows and browns be taken into consideration as well as the more startling greens and mauves?

Next, floral decoration; praiseworthy as the recent effort with ferns and daffodils may have been, yet pathetic was the result. One was reminded of the dismal aspidistra in the Victorian front-room. Flowers can lend an air of friendliness to almost any surroundings but their arrangement is an art. Surely this is not entirely lacking at Guy's.

Lastly, the problem of service—to be mentioned only with some diffidence. Granted the demand comes at certain peak hours, nevertheless the queues for main dishes, tea and coffee, are getting larger, rather than otherwise. If the kitchens are still inadequate, are further re-arrangements quite impossible? If equipment, especially cups and glasses, is a limiting factor, cannot further supplies be procured? So far as staffing is concerned, the women at present engaged work tremendously hard, but are their energies always economically directed? Coping with all the meat courses, vegetables and soup three servers put up a most creditable yet not always successful display. Meantime, the bread-and-butter and cold drinks, for which there is a very limited call, engage the complacent attention of two more full-time workers. Recovery of dirty crockery from the tables, which so often seems to develop into a physical contest against odds, consumes the efforts of three or four more people. If customers are capable of carrying their loaded dishes from the serving counter is there any reason why they should not return the empty platters afterwards to the washing-up room?

Grievances are thus listed and possible remedies indicated. What is always uncertain, however, is the proper authority at which such remarks should be directed. Is it the Students' Club, the College Catering Company or the Supervisor-in-charge? All, no doubt, have their difficulties and are making earnest efforts to overcome them. But there is a mystery about the whole process and, in consequence, an undertone of discontent pervades the student body. To counteract this, a statement in these columns from those who at present shoulder the burden of catering in silence would be most welcome.

Yours, etc.,

AGRICOLA.

Guy's Hospital, S.E.1.

Out-Patient Appointment List

SER,—Iur correspondnt abowt the astma klinic kwd, if he had reformed hiz spelling, hav mayd hiz letter iivun shortr . . . and iivun mor obskur.

Ei am, Ser,

JUDE.

Guy's Hospital, S.E.1.

Sport

HOCKEY

FINAL ROUND HOSPITALS' CUP
GUY'S *v.* LONDON

at Chislehurst. Won 2—0.
16th March, 1949.

By winning this match, Guy's H.C. retain the Hospitals' Cup for another year.

They bullied-off in bright sunshine on a perfect pitch, with the wind and half-a-hundred vociferous cheers in Guy's favour. The match developed into a battle between defences, which the forwards rarely managed to penetrate. Half-backs of both sides gave of their best and the only good hockey was to be seen in mid-field. The winning goal was scored in the first half of extra time.

Guy's forwards were slow in getting to the ball and London were soon pressing hard. The defence remained calm and cleared hard and well, often from inside the circle. A penalty corner for Guy's gave D. Blake a shot which the keeper did well to save.

After the change-over the ball was swung to and fro by both sides, and it was a pity to see many good movements broken by quickly-covering defences. At length Guy's forwards settled down. C. Opie broke through only to shoot over the top, and the London goalkeeper again saved well from D. Blake.

Extra time: Guy's launched several attacks. A centre from C. Opie enabled D. V. Duckworth to flick and follow through, to score from a melée in the goal-mouth.

The teams changed ends and London were back to the attack straight away. An inside forward was slow in following up and missed an open goal. There were good saves from short corners by E. A. Murray, F. Walker (goal) and G. Danford, and at the final whistle, Guy's were still defending stoutly.

So ended a most enjoyable game, played in the best Hospitals' spirit. It is incidental that Guy's thereby also gained a victory.

Team: F. Walker; G. Danford, D. Sonnenfeld; C. Robinson, E. A. Murray (Capt.), L. Mackey; D. V. Duckworth, D. Blake, S. Earl, C. Opie, R. Hodson.

Season record to date:—

P.	W.	D.	L.
31	29	1	1

FINAL ROUND
LONDON UNIVERSITY
INTER-COLLEGIATE CUP
GUY'S *v.* IMPERIAL COLLEGE

at Motspur Park. Won 3—2.
2nd March, 1949.

GUY'S *v.* ROMFORD

at Romford. Won 5—1.
19th March, 1949.

SAILING CLUB

At the Annual General Meeting of the Sailing Club, the following Officers were elected:—

Commodore: Sir Heneage Ogilvie.
Vice-Commodores: Mr. C. P. Nicholas and Dr. K. O. Rawlings.
Secretary: J. W. Bradbeer.
Treasurer: J. R. Rees.
Committee Members: A. P. Blower, R. Longmore, B. Wilshere.

The 25th Season of the Sailing Club starts at Burnham on April 2nd.

Details of membership can be obtained from any member of the committee or the secretary, who will be in the S.U. Office on Thursdays from 1.0 p.m.—1.30 p.m.

ASSOCIATION FOOTBALL

INTER-HOSPITALS' CUP SEMI-FINAL
GUY'S *v.* CHARING CROSS AND ROYAL DENTAL

at H.O.P. Won 3—1.
9th March, 1949.

Guy's managed to reach the final for the seventh successive year at the expense of a much-improved and ultra-keen Charing Cross and R.D. team. Perfect playing conditions and a crowd of sizeable proportions (mostly supporting our opponents alas) greeted the teams, and from the kick-off Charing Cross decided that what they might lack in individual skill would be more than compensated for by enthusiasm. For the first ten minutes they were yards faster than Guy's who seemed apathetic in comparison. There were several close shaves for the home side and then tragedy befell Guy's when Swift was taken off with a knee injury, not to return. Worse followed when the Cross scored a good goal.

This produced more resolution in the Guy's team, and purposeful work by Skaith on the right wing enabled Lewis to score from the ensuing cross. Shortly after, Oldfield on the left paved the way for Lewis' second goal. Guy's defence now showed its mettle. Full backs Lipington and Howells tackled with customary vigour. Young barred the centre completely, and behind them Fearn was very safe. Half-time and we were on top, leading 2—1.

The second half was all Guy's. Wing halves Matthews and Leckie, who had taken Swift's place, dominated all the mid-field and provided their forwards with many opportunities. That these were not turned to better account can only partly be attributed to the Charing Cross defence. Far too much individualism which gave their defence time to cover spoilt many movements and the only score was a truly magnificent shot by Sturdy who hit a left-foot shot on the turn following a quick throw-in.

Guy's suffered another injury when Young twisted an ankle and he was forced to play the final ten minutes at right wing. And now to the final. Once again we play Mary's, and we hope a large band of supporters will see us reverse last year's defeat in the final. The game will be played on Tooting and Mitcham F.C. Ground, Sandy Lane, Mitcham, on Wednesday, 30th March, 1949. Kick-off 3.15 p.m. Your vocal support is urgently needed.

CROSS COUNTRY RUNNING

Barts' won the Inter-Hospitals' race for the Kent-Hughes Cup, held over the United Hospitals' five mile course at Petersham on Saturday, March 12th.

The small, but keen Guy's team ran well, packing fairly closely, and finishing second to the larger and stronger Barts' team. Hartley did especially well for the Hospital, coming in seventh out of a field of over forty. John Menon (Barts') was the individual winner in 29 minutes 7 seconds, and D. Griffiths (Guy's) won the handicap.

The meeting was honoured by the presence of Dr. H. A. Munro, formerly of Guy's, and under whose ægis the United Hospitals' Hare and Hounds club saw its inauguration in 1886.

Given increased support by cross-country men at the Hospital, Guy's should stand a very good chance of winning the Cup at next year's championships.

Result: (1) Barts .. 31 points.
(2) Guy's .. 55 ,,
(3) Middlesex .. 61 ,,

M.K.S.

Hospital Information, etc.

WAR MEMORIAL APPEAL

DONATIONS RECEIVED UP TO
30th NOVEMBER, 1948

Total at 31st October £1,308 8 8

£10.—Forman, L.; Guy's Hospital Employees. £5 5*s*.—Carter Braine, J. F.; Crisp, E. J.; Curtois, G. M.; Doubleday, F. N.; Johnston, Professor T. H. B.; Loxdale, H. A. R.; Marshall, C. H.; Marston, A. D.; Pringle, K. E.; Hulett, J. M. £5.—Hardwick, C.; Jap, A.; Nelson, E.; Mackenzie, L. G. £3 3*s*.—Kyle, J.; Payne, R. Vaughan; Salmon, L. F. W.; Scholefield, B. G.; Southwell, N.; Stoneham, F. J. Russell; Foote, E. S.; Whillis, Professor J. £3.—Clarke, P. S.; Neser, E. E. £2 10*s*.—Harley, H. R. S. £2 2*s*.—Alban-Jones, D. J. A.; Andrew, J. B.; Blachford, R. D.; Blazeby, Dr. and Mrs. H.; Bolt, K. W.; Bulstrode, J. C.; Chazen, S. H.; Douglas, C. G.; Ive, C.; Joynt, E. P. H.; Kinghorn, A.; Lay, R. A. Q.; Lee, H. A.; Mindham, W. F.; Musgrove, A. H.; Pantin, C. G.; Reynolds, L. L. C.; Roberts, D. B.; Sagorin, L.; Schabort, J. W.; Strong, S. U.; Stuart-Menteth, W. E.; Trounce, D. Q.; Wallis, F. R.; Weinbren, M.; Weston, J. G. £2.—Anderson, J. H.; Court, P. F. S.; Gibb, A. E.; Gilbert, F. W.; Littler, N. P. W.; Ripman, H. A. (omitted from October list). £1 10*s*.—Hilliam, I. H. and A. W.; Osmond, H. £1 1*s*.—Aling, G. E.; Carden, W. A.; Carnegie, D. M.; Cooper, Sir Patrick Ashley; Cox, A. G. C.; Cunard, J.; Denny, R. L.; Donald, J. K.; Drewitt, A. H.; Evans, W. D. P.; Graham, A. J. P.; Grummitt, P. C.; Heber, A. J.; Hodgson, W. Archer; King, R. M.; Landsler, A. S.; Lean, W. H. C.; Lee, A. B.; Lyle, G.; Porter, W. A.; Prideaux, B. H.; Reeve, E. B. G.; Robinson, A. D.; Russell, J. F.; Skelton-Browne, N. H.; Smith, Miss D. M.; Staley, R. W.; Swan, J. F.; Trick, S. R.; Wallace, J. D.; Weller, G. N. S. £1.—Duncombe, Miss M. A.; Grant, R. T.; Khong, K. T.; Martindale, V. H.; Penny, E. A.; Pye-Smith, C. D.; Rayner, G. R. C.; Strange, Dr. and Mrs. D. M. 10*s*. 6*d*.—Eckstein, P. 10*s*.—Orozco-Casorla, R.

Total .. £1,543 11 8

Donations received between 1st December and 31st January already published.

DONATIONS RECEIVED UP TO
28th FEBRUARY, 1949.

Total at 31st January, 1949 .. £1,691 2*s*. 8*d*

£5 5*s*.—Pringle, L. D. £5.—Wilkinson, Miss A. £3 3*s*.—Stiven F. W. £2 2*s*.—Pisani, P. I. £2.—Perkins, H. E. £1 1*s*.—Brown, P. E.; Davidson, Mrs. J.; Lawson Smith, Mrs. W.; Oldendorff, Miss L. G.; Opie, Miss E. A.; Richmond, A. G.; Smyth, Miss G. D. S.; Wallace, L. J. £1.—Cashmore, W. W.; Davies, Mrs. E.; White, Miss M. 10*s*. 6*d*.—Lyons, Miss L.; Walmsley, C. G. 10*s*.—Broom, Miss B. M.; Mills, Mrs. R. B.; Moore, Miss P. L.; Powell, Mrs. R. E.

Total .. £1,723 1*s*. 8*d*.

CLUBS' UNION

Acting upon the results of the referendum recently conducted, the Clubs' Union Council, at a special meeting on Tuesday, 15th March, 1949, resolved :—"That a recommendation be sent to the School Council for membership of the Clubs' Union to be compulsory for all students of the Medical School, this provision to be instituted for a trial period of five years, dating from 1st October, 1948."

G. D. CHANNELL,
Honorary Secretary.

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from registered Dental Practitioners for the post of **Full-time Assistant** to the **Visiting Dental Surgeons** to Guy's Hospital. Duties will comprise assisting with the clinical treatment of patients referred to the Dental Department of the Hospital and the instruction of students. The post will provide excellent facilities for a person who is studying for a higher degree or diploma. Salary £750 per annum, plus superannuation and family allowance (subject to revision after the publication of the Spens Report). Duties to commence as soon as possible after the 9th May, 1949.

Forms of application are obtainable from the Dean, Guy's Hospital Dental School, London, S.E.1, to whom applications should be sent not later than 8th April, 1949.

Applications are invited for the appointment of **Assistant Dental Surgeon** to Guy's Hospital, attendance on two sessions per week with remuneration at the rate of £200 per session, subject to revision when the new Ministry of Health scales and salaries are published. The appointment is of consultant status. Applications (one copy), with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, by 27th April, 1949. In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of Members of the Board or Advisory Appointments Committee will lead to disqualification.

NOTICE

Volume 2 of Watson-Jones' "Fractures and Joint Injuries" is missing from the Surgeons' Library. Would the borrower please return this book as soon as possible to the Department of Surgery.

H. J. B. ATKINS,
Director.

CHANGE OF ADDRESS

N. G. Nicholson, M.B., B.S., "Mirama," Canford Cliff Avenue, Parkstone, Dorset.

BIRTH

GOULDER.—On March 18th, 1949, at the Maternity Unit, North Herts and South Beds. Hospital, to Margaret (née Oliver), wife of Dr. R. V. H. Goulder, a daughter (sister for Nicholas).

MARRIAGE

BAILEY—CORNISH-BOWDEN.—On February 26th, at Wolborough Parish Church, Newton Abbot, L. J. Bailey, L.D.S. (Eng.), 5, York Row, Wisbech, to Elizabeth Cornish-Bowden, of Newton Abbot, Devon.

DEATHS

COCKCROFT.—On March 24th, 1949, George Cockcroft, M.B., B.S., of Middleham, Yorks.

NICHOLSON.—On March 11th, 1949, Professor Gilbert W. de P. Nicholson, M.D. B.Ch., Clinical Microscopist to the Hospital (1944), 20, New Square, Cambridge.

WATT.—On March 6th, 1949, at the R.N. Hospital, Plymouth, Frederick William Watt, Surg.-Capt. (D) R.N., aged 55 years.

Eds. { H.A.R. R. G.

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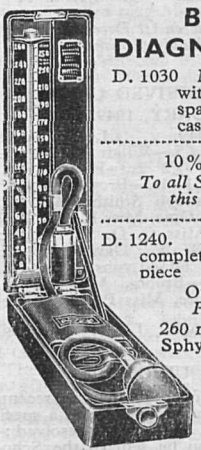

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GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXIII. No. 1584 *9th April* 1949 *Ninepence*

PASSIM

AFTER nine and a half years, it was a rare treat to see the lights of Piccadilly turned on again, in all their splendour. London rolled up to look at them in such strength that it took half an hour to go by car from the Atheneum to Swan and Edgar's. But it was worth it, for whatever one's views on Guinness, Schweppes or Bovril, surely this background of bright lights is the right one for Eros. It took one back to other Saturday nights, long, long ago it seems, when deep underneath the Criterion could be found most of Guy's and many another rugger club, satisfying their appetites, quenching their thirsts, celebrating a victory or not taking too seriously a defeat. It did one good to recapture a moment or two from the past. Life for a second became, not yet what it was, but better than it has been.

Two days later, on Monday last, other lights made history at Guy's, for on that day the newly installed calling system came into use. Placed at thirty different vantage points in the Hospital to-day are the four-light-frames, which are connected to the switch-board in the College Lodge. At the flick of a key by the porter-on-duty, one, two, three or four coloured lights, either steady or flicking or some one, some the other, and in any one of a phenomenal number of combinations, shine in every ward, on each floor of the Out-Patient Block, in the Front Surgery, Nuffield House, the Staff Common Room, the Residents' Room and the Dining Hall, and he who is beckoned rings the College Lodge to receive his message. By this means it is hoped there will be a considerable speeding up of the inter-communications of the Hospital. Doctors from without should now be able to contact housemen with a minimum of delay. Patients on the surgery and in the wards should now receive the attention demanded at the moment, with greatly increased alacrity. We would like to congratulate the authorities on this potentially great advance. But "potentially great" it will remain until either we all become such contortionists that wherever we are and whatever we are doing, we are always in sight of and facing a light-frame, or until such time as, having become accustomed to the system, every department has educated itself to know the call-signs of the half dozen or so Hospital servants who customarily habituate their precincts. There are two factors to help them. In the first place each light-frame has a code-board close by for reference. In the second, the authorities have been sufficiently far sighted to allocate code-signs to posts rather than personnel. It is workable if we make it so, but there are bound to be some growing pains.

IT is with a long awaited pleasure that we greet Mr. Noel Glover on his return from the United States of America, where he has been for six months. He says he sure enjoyed himself.

SOME extremely wild statements have appeared in the press concerning the result of the Hospital Rugger Cup Final. St. Mary's Hospital beat Guy's by 6 points to 5. It has since been realised by both teams that the manner in which St. Mary's winning try was scored is not allowed by the rules of the game. St. Mary's, in the person of their captain, Mr. Summerskill, came over to Guy's and offered a replay. Our captain, H. Brunow, representing the opinion of the Hospital, declined the offer in the spirit which one would expect of him.

FOUNDER'S DAY SERVICE.—A Service will be held in the Guy's Chapel on Friday, May 6th, at 1.15 p.m., to commemorate our foundation by Thomas Guy.

"Blood Pressure"

A Clinical Lecture delivered at Guy's Hospital by Charles Baker, O.B.E., M.D., F.R.C.P., on February 1st, 1949.

GENTLEMEN,—For this clinical lecture I deliberately chose the title "Blood Pressure" in inverted commas, rather than Hypertension. Blood Pressure is a vague and woolly term engendered by the sphygmomanometer, sometimes used by patients as a symptom and sometimes by the profession as a diagnosis to cover a state of chronic physical or psychological ill-health. It is in fact neither a symptom nor a disease and we must not be content with it as a diagnosis. The level of the blood pressure is a physical sign only. A pioneer in devising an instrument to measure it was a Guy's physician, Dr. F. A. Mahomed (parochial applause), who about 1879 thus made possible an easy recognition of the generalised disease first described in 1872 by Gull of Guy's and Sutton of the London as Arterio-Capillary Fibrosis, later known as Hyperpiesia and now as Essential Hypertension. The public, who like to regard Medicine as an exact science, are impressed by precision expressed in figures, and doctors too are often content to lean to the complacency and certainty of figures—whether a blood sugar, a blood urea, or a blood pressure reading—and thereby to assume a comfortable dogmatism in the doubts and difficulties of clinical problems. Though patients are impressed by the sphygmomanometer they are also frightened by it, for to many of them it is a machine which will reveal the disease of "Blood Pressure," which will cause them to drop dead in their tracks, to go to bed never to wake in the morning, or to be overtaken by a sudden stroke or the dreaded dropsy. How common it is in a routine examination to have an anxious query, often the only one, "How is it Doctor?" when the blood pressure is taken; and for one who asks there are many who are afraid to ask. The sphygmomanometer can be a dangerous machine which may cause us to be misled and to mislead our patients, and "Blood Pressure" is often a doctor-made or Iatrogenic Disease. My object to-day is to attempt to correlate and clarify the physical sign of a raised blood pressure reading with the presence or absence of the disease Hypertension. In the last few years there has been much work, both clinical and experimental, on the ætiology of Hypertension which is of great importance, and treatment by sympathectomy is another example of the activities of surgeons making it imperative for physicians to take stock. Of this recent work I shall touch only as far as it affects our day to day management, in out-patients or in practice, of the patient who shows a raised blood pressure reading:

	BRITISH	AMERICAN	TRUE
SYSTOLIC	Appearance of sounds (Palpatory level, if higher)		Sounds + 10 mm.
	SILENT GAP		
FALSE SYSTOLIC			
DIASTOLIC	Sounds change.		
	up to	10 mm.	
		Sounds disappear.	Sounds disappear.

CHART I.

THE BLOOD PRESSURE READING.

It is essential to have the patient comfortable and relaxed, preferably reclining, with the cuff of the instrument evenly applied without constricting garments. The

mercury sphygmomanometer is more reliable than the small and handy anæroid type, which needs periodical testing. What are the correct systolic and diastolic pressures? The joint committees of the American Heart Association and the Cardiac Society of England and Ireland which met in 1939 had no difficulty in agreeing about the systolic level but they differed about the diastolic level. I have illustrated the differences (Chart I) and also shown how the pressure estimated indirectly by the sphygmomanometer compares with the pressures taken directly from the blood stream in the vessel. You will see that the American assessment of the diastolic level is nearer the true pressure but it has the disadvantages that the level at which the sounds disappear depends on the keenness of the individual ear and that one often finds patients—with and without aortic reflux—where the sounds are heard softly for a long distance below the diastolic level. There is, however, always a fairly abrupt change in the character of the sounds, and thus the British method should get more consistent readings between different observers which after all is more important than a true pressure. The practical points are that it will be assumed in this country that the diastolic pressure you record will *have been obtained by this method, and that you should remember when assessing* American figures that their standard of normality will be lower than ours.

THE SIGNIFICANCE OF A RAISED PRESSURE.

Before proceeding any further I must mention two important points. The first I do not think needs much stress for you are aware that Essential Hypertension is a diagnosis of exclusion and you must always think of Renal Disease as well as other rarer causes such as Endocrine Disease and Coarctation of the Aorta. The second is that *Hypertension must not be diagnosed on a raised systolic pressure alone, for this will* occur when there is increased cardiac output as in Aortic Incompetence or Hyperthyroidism, or with rigidity of the aorta and large vessels in Atheroma. It is a common finding in older folk with rigid vessels to find a systolic pressure as high as 200 with a diastolic below 100, and it is a mistake, all too common, to diagnose this as Hypertension. Hypertension is a disease due to increase in peripheral resistance from the arterioles which causes a raised diastolic pressure, and though both levels must be raised to make this diagnosis the diastolic is the more important. Whether this increased peripheral resistance is primarily due to pressor substances formed in ischæmic kidneys or whether due to "neurogenic" influences through the sympathetic nervous system is not decided. Both undoubtedly play a part in the established case and in addition there is often a hereditary predisposition which may be endocrine in mechanism.

We know neither the cause nor the mechanism of hypertension nor do we know whether it is one or more than one disease. It does, however, seem clear that transient rises in pressure due to spasm of the arterioles are followed by a permanent raised pressure due to organic changes in those vessels, and though the speed of this change differs greatly in the individual case, the essential course is the same. In this complex problem, amid the speculations of theory and the enthusiasms of new treatments, this is at least something which may guide us in treating our patients. In this condition, which is usually progressive but very variable in the rate of progression, I think it is helpful to recognise four stages:

1. Labile Blood Pressure, or Transient Hypertension.
2. Established Hypertension without other signs.
3. Established Hypertension with other signs.
4. Hypertension with Failure.

TRANSIENT HYPERTENSION.

It is almost the rule to find that the first time the blood pressure is taken the systolic reading particularly, and the diastolic to a lesser extent, are higher than on subsequent readings at the same examination or at subsequent visits. The main reason for this is due to the tension and nervousness caused by the ordeal of a medical examination, which must be quite severe in a crowded out-patients, and often by the apprehension that some fell disease will be thereby exposed: other less important factors which cause too high a reading are an uncomfortable position, cold, or a recent meal. If you leave the cuff in place while completing the examination and particularly if you can spend some time talking to the patient and can reassure him that nothing serious has been found, you will find that a reading later will usually be lower. This does not always happen, because the patient is still nervous, in which case a lower reading will be found on subsequent visits. It is rare that the first reading is the true figure, though in well

established hypertension with very high readings this may occur, in which event there will be other signs of the disease. Even when consistent readings have been obtained on more than one recording it is still possible to get a lower reading if the patient has been in bed for 24 hours or more. Despite this we still find the first reading on admission to the unfamiliar and often frightening surroundings of a general ward recorded in the notes as The Blood Pressure as though it was as established a fact as the patients height. It should be our object to get the lowest blood pressure possible from our patient; this is the true indication of the state of the circulation and is the Basal Blood Pressure. The Supplemental Blood Pressure is the rise above this level due to exertion, temperature, posture, and emotion giving a fluctuating level or Casual Blood Pressure, which is well named particularly if we are content with it as a true record on which to base diagnosis, prognosis and treatment. The increase in supplemental pressure due to the common factor of emotion is widely recognised and I am quite sure that with a tense patient we often deliberately cheat, and knock off a few mms. from the level we hear to the figure we record in our notes. If it is impossible to see the patient again, and when we know that the casual blood pressure may be misinterpreted as a basal blood pressure, this is not a bad thing. Nevertheless, although this is often done with impunity and confidence as regards the systolic pressure, it is not so readily done with the diastolic pressure, which is the more important figure. It is often said that though the systolic may vary greatly from moment to moment and with emotion, the diastolic pressure remains constant. This is not so, and it is not rare in nervous people to find a diastolic of 110 at their first visit, and a reading of 90 or lower at a subsequent visit. If this is not appreciated a misdiagnosis of Hypertension, with all its consequences, will be made. There is no doubt in my mind that the best thing is to record the Casual Blood Pressure each time, to realise that it is such, and to recognise this harmless stage of lability of the Blood Pressure as Transient Hypertension.

Now, although the majority of patients we see with this transient rise have not got Hypertension and never will get Hypertension, there is evidence that a small proportion do subsequently develop permanent or Established Hypertension. An example of this evidence was an investigation instituted in America during the war, with the very practical point of view of establishing whether it was reasonable and safe in enlistment to the services to neglect the supplemental pressure which gives transient high readings. The Army records, with Blood Pressure readings, were available for 22,741 officers, 84 per cent. of which were from 5–19 years and 38 per cent. from 15–19 years, and made an excellent basis to see how the minority of those whose blood pressure fluctuated fared, compared with the majority where it was constant. The analysis of the follow-up of this large group is published in a series of papers by White, Levy, Stroud and Hillman. They found that Transient Hypertension increased with age, and that in all ages Established Hypertension developed more frequently from those showing Transient Hypertension than *de novo*, and that retirement or death from cardiovascular disease was more common in those who had shown Transient Hypertension than in those who had not. Additional findings of interest were that if Transient Tachycardia or Obesity were also present the probability of Sustained hypertension and cardiovascular disease was increased; two of these three factors were more important than one alone, while if all three were present it was a circumstance of prognostic significance. No doubt if it had been possible to correlate family history as well this would also have been significant. There is also evidence that those who show increased lability of the blood pressure by a marked rise when the hand is immersed in cold water (Cold Pressor Test of Hines and Brown) are more liable to develop Established Hypertension later. You can see that there is justification for Insurance Companies refusing people who are found to have a high blood pressure reading even when a low basal pressure could be established, for although this is unfair to many who will never develop true Hypertension, it eliminates a certain number who will. It is interesting to speculate why Transient Hypertension may develop into Established Hypertension. Is there some factor at work which manifests itself at first by a greater lability and tendency to transient rises, or does the summation of these transient rises in a susceptible subject over a period of time eventually cause permanent damage by wear and tear? But this speculation will not help the patient where we find this transient hypertension. What is our duty to him? I would summarise it as—

1. Not to diagnose Established Hypertension unless there are frequent high readings in basal conditions.
2. If routine examination is negative, to reassure him. The more nervous the patient, the more will reassurance be justified.

3. Not to mention the word Blood Pressure unless it has already been mentioned, in which case additional reassurance will be needed: and to point out that "Blood Pressure" is not a disease.
4. If there is obesity, or transient tachycardia, or a family history of hypertension particularly in a person who is *not* nervous, subsequent examinations at long intervals are indicated, but it must be made clear that these are entirely routine and do not mean that disease is to be anticipated.

ESTABLISHED HYPERTENSION WITHOUT SIGNS.

What level are we to consider as constituting Established Hypertension when we have ruled out Transient Hypertension? What systolic and diastolic levels in an adult can we regard as abnormally high? The figure 150/90 consistently found is often quoted, particularly in America where they take their diastolic level as lower than ours. This is certainly a safe figure if we are only concerned with our own safety in prognosis and prestige, but if one takes the diastolic as the level at which the sounds change, I personally feel a higher level of normality is reasonable. Unless a patient has been in bed for a day or two, I do not diagnose Hypertension unless there is a consistent reading of 160/100 or above. It is wise even then not to be too dogmatic or hidebound about absolute levels though some standard is a necessary discipline. We must then estimate the significance of this diagnosis. Symptoms are not helpful and often misleading for those which may occur with Hypertension—dull headaches, irritability, nervousness, faintness, palpitation, brain fag, and physical fag—occur with equal frequency in non-hypertensive psychoneurotics. We must therefore look for signs of Hypertension. I have no time to elaborate these signs but have listed them in Table 2 as Circumstantial, Reliable Clinical signs, and Additional signs derived from X-ray and Electrocardiographic examination. The circumstantial signs of thickened and tortuous arteries are due to

SIGNS OF HYPERTENSION.

CIRCUMSTANTIAL	CLINICAL	ADDITIONAL SIGNS
Thickened brachial and radial arties.	Apex beat forceful and out to the left.	Enlargement of the left ventricle on X-ray.
Tortuous brachial and radial arteries.	Apical systolic murmur.	Left axis deviation with T. inversion in Lead I.
	Triple Rhythm, if in failure.	
Pulsation in the Neck.	RETINAL ARTERIES.	
	Urine.	

TABLE 2.

associated arteriosclerosis, while pulsation in the neck is seen in other conditions than hypertension so is not infallible. Of the clinical signs there is no doubt that the state of the retinal vessels is the most helpful but the most difficult to appreciate and assess. The additional signs are confirmatory evidence, and an inversion of the T wave in Lead I with Left Axis Deviation is strong evidence that Hypertension is not only present but having an effect on the heart.

What is our duty to the patient in the *absence* of signs in Established Hypertension? Prognosis must be guarded for we know that these people have a liability to Cerebral Hæmorrhage and to Coronary Occlusion. But in the absence of signs, these dangers are not great and I do not think we are justified in alarming the patients with them, and apart from guarding against extreme and sudden exertion no restriction of activity is justified. Many of these people do extremely well for many years, particularly the women, and though the majority will progress to the stage where signs are present and even to the stage of failure, there is no need to anticipate this and make their lives miserable by present inconveniences or fears for the future. They should be seen at regular intervals for the prognosis depends on the speed with which changes are observed, either in the increasing level of the blood pressure or the development of signs. At this stage, without other signs, reassurance and symptomatic treatment are alone necessary, and though they would do well with sympathectomy, there are many, particularly women,

who have attended their doctors or out-patient departments over many years, who are examples that they do quite well without.

ESTABLISHED HYPERTENSION WITH SIGNS.

The signs of hypertension, apart from the raised blood pressure, are due to the effects of the disease on the kidney, the brain, the heart and the eyes. The prognosis will in part depend on the extent to which these organs are involved, for with the exception of the eyes the effects of vascular disease on these organs may in itself cause death. More important however is the degree of the more generalised vascular change and here two points are most helpful, the height and fixity of the systolic and diastolic levels and the state of the retinal vessels. The importance of the height of the blood pressure in prognosis is obvious though it must be remembered that it may drop terminally in hypertensive failure, but a fixed level which is not lowered appreciably with rest and sedation is also a bad sign. The state of the retinal vessels is the most important individual sign in prognosis for though it is an assumption that they represent the state of vessels elsewhere, both clinical experience and biopsy have shown that such assumption is a reasonably one. If retinal changes are present there is no doubt that Hypertension is established and the degree of these changes is an indication of the stage to which it has progressed, and the most reliable sign on which to base prognosis. This was well shown by Keith and Wagener in a five year follow up of 200 cases divided into four groups on the degree of retinal changes, and their classification has been most useful in assessing the results of sympathectomy. I have only time to indicate their findings roughly.

GROUP.	DEGREE OF RETINAL CHANGE.	5-YEAR MORTALITY.
1.	Mild narrowing of arteries	30 per cent.
2.	Marked narrowing	46 per cent.
	Irregularity	
	Arterio-venous compression	
3.	2 + Cotton wool patches	80 per cent.
	Hæmorrhages	
4.	3 + œdema of discs	99 per cent.

These figures indicate that Hypertension with signs and particularly retinal signs is a serious disease and a very different problem from Hypertension without signs. Yet, even with signs, the progression may be slow and prognosis relatively good. Since it is in cases with steady and rapid deterioration that we are justified in attempting to halt this progression with sympathectomy, how are we to assess the march of the disease? A careful history is often helpful and, at this stage the onset, degree and increase of symptoms, particularly headache, are useful and may in themselves warrant intervention. If there is any doubt, repeated observations with particular attention to the retinal changes are indicated rather than rash decisions. The outlook is poorer in those where changes occur early in life, in men as compared with women, and in those with a family history. Treatment in these cases is symptomatic, in which at the present I include sympathectomy, and some restriction of activity is justified and often essential. In this respect it is often the speed and pressure of work rather than the hours spent that need adjustment, for many are made miserable by enforced retirement and appear to die of boredom rather than their disease. Apart from the treatment and avoidance of obesity, restrictions of diet, alcohol, and tobacco are rarely justified and the profession to-day is less guilty of inhuman embargo than it was. The picture of the great George Saintsbury in retirement at Bath, after a life-time devoted to the cultivation and appreciation not only of literature but of his palate—he was the author not only of the History of Prosody but of Notes on a Cellar Book—condemned by his Doctor to drink no red wine is one which makes one ashamed of the Medical Profession.

HYPERTENSION WITH FAILURE.

I have no time to deal with this stage in detail and the main points are indicated in Table 3. Many patients will have been observed passing from the preceding stage, but some, particularly those with Malignant Hypertension, will first appear in failure. It is worth pointing out that the liability to stroke from hypertension is not as great as I

think most doctors, and certainly the public, suspect. A rough indication of the type of death in Hypertension is :—

Congestive Failure	50	per cent.
Stroke	15	,, ,,
Coronary Artery Disease	15	,, ,,
Uræmia	8	,, ,,

which leaves 12 per cent. whose Hypertension is not fatal, an important point to remember.

		Symptoms	Prognosis	Treatment
1.	Transient Hypertension	Not due to organic disease.	Good	Reassurance.
	Possibly			
2.	Established Hypertension without Signs	May be due to organic disease.	Good but guarded.	Reassurance and periodic examination. No restriction of activity justified. Sympathectomy unnecessary.
	Probable but often slow			
3.	Hypertension with Signs — Coronary Disease / Stroke	Are due to organic disease.	Depends on the tempo and degree.	Restriction of activity justified. Sympathectomy may help.
4.	Hypertension with Failure		Bad.	Restriction essential and active treatment imperative. Sympathectomy too late.

Table 3.

In conclusion, be chary in diagnosing Hypertension ; it is done too often. Avoid hasty decisions which should wait on observation. Do not diagnose Blood Pressure. Nothing I have said to-day is new but old truths may be forgotten in new enthusiasms, and to illustrate this let me quote what the father of modern cardiology, Sir James Mackenzie, wrote many years ago, having used the sphygmomanometer from its earliest days.

" I took records of a good many people whom I could keep under observation. In some I found the pressure vary remarkably. At some examinations, it would be 180 mm., a few days later it would be 120. I could find no cause for such variations. In some liable to attacks of angina pectoris, the liability was as great when the blood pressure was low as when it was high. Some with high blood pressure got heart failure, or apoplexy, and died ; others lived and pursued their occupations with no limitation for the years I have been able to watch them. When I came to inquire into the difference between these various types, I found that the former were always associated with evidences of disease of the heart, kidneys, or blood vessels, of such an extreme degree that a sure prognosis could have been given apart from the blood pressure. On the other hand, those who pursued a normal life presented no changes in other organs, beyond what one would consider compatible with their time of life. In giving a prognosis, therefore, I am accustomed to review critically the condition of the kidneys, the state of the arteries (inquiring if there has been any hæmorrhage), and the condition of the heart, with particular reference to its size and functional efficiency. It is on the result of such a review, with the knowledge of the blood pressure, that I base a prognosis."

Obituary

Professor Nicholson.

WITH the death of Professor Nicholson on March 11th, within a month of his 71st birthday, the family of Guy's has lost an outstanding personality and the world a great pathologist.

Gilbert William de Poulton Nicholson was the son of Gilpin Nicholson, of Balrath, in the County Meath, and his mother was the daughter of Professor Bruxwitz, of Saxe-Coburg. He was educated in Germany until the age of 16, when he came to England and, after spending three years with a tutor, went up to Jesus College, Cambridge. He entered Guy's in 1902. He first became interested in morbid histology when, as a dresser, he was appointed section-cutter of the Surgical Registrar, an appointment which he held for several years. Qualifying M.B., B.Ch. in 1905 he proceeded to M.D. in 1907 with a thesis on the Classification of the Tumours of the Testis, which brought him early fame as a morbid histologist and is, to this day, quoted in the text-books. It was in this year that the Medical Committee wisely decided that his talents were suited to medical research rather than to Clinical Medicine and recommended him for the Gull Studentship of Pathology, which he held for two years. There followed a period in the laboratories of Cambridge, from which he was recalled in 1913 to fill the newly created post of Morbid Histologist to the Hospital, which he occupied until his retirement in 1944. The title of Professor of Morbid Anatomy was conferred on him in 1928, and that of Emeritus Professor in 1945, "in recognition of his distinguished services to the University and Morbid Anatomy."

Nicholson has left a lasting memorial in Pathology of his work on the morbid anatomy of tumours, and particularly for his original and critical evaluation of the pathogenesis of the teratomata. Before he tackled the main problem of teratology the subject lay in a chaotic state of conjecture, false theory, and valueless impression: to this Baroque monument of confusion he has brought a Gothic-like simplicity, which has stood the test of time and of experimental biology.

A measure of his worth as an oncologist can be gauged from the fact that subsequent discoveries in experimental carcinogenesis have only confirmed the validity of his views on tumours. When one considers the extent and depth of his writings on the subject over a period of some forty years it is remarkable that there is no need to retract a single word he wrote.

Besides being the foremost teratologist of his day, Nicholson was among the three or four best morbid histologists in the world, and his opinion on sections was sought from far and wide.

He cannot be said to have been a good teacher. Routine classes were always irksome to him, and a nervousness, when confronted with an audience, was a great handicap. But to anyone who was genuinely interested in his subject he would open his heart and give freely of his vast store of knowledge and experience, and those who gained admission to the intimacy of his sanctum in Guy's House regard themselves as fortunate indeed to have known and learnt from so great a master.

Nicholson was a man of moods, and to those around him he could be charming or, on occasions, extremely difficult and unreasonable. His Irish-German descent and his early life in the stilted and conventional atmosphere of Coburg were probably responsible for a habit of intolerance and a brusqueness of manner which never quite left him, and which were apt to create an unfavourable impression with people who met him for the first time, and sometimes led to misunderstandings with his colleagues. Those who knew him well realised that he was really one of the kindest and most generous of men and the truest of friends. He loved children and understood them well, and there must be many, now grown up, who cherish the memory of happy hours spent with him in their childhood days.

Outside his work he was fortunate in having hobbies, which took him out of London into the pure air of the country. He was a great walker in his younger days and an ardent naturalist, and he was never happier than when rambling among woods and fields in search of beetles, of which he amassed an enormous collection, and on which he was a noted authority. On these occasions he was the most delightful of companions, and a fund of information on birds and flowers as well as insects.

From his undergraduate days he always had a great affection for Cambridge and the

Fen Country, and on his retirement from Guy's he went to live there, almost under the shadow of his old college. Though his health was failing his last five years were happy ones, and his final illness came suddenly and was mercifully short.

Dr. George Cockroft

GEORGE COCKROFT came up to Guy's in October, 1900, and went into the dissecting room in October, 1901, where he was one of that remarkable quarter, all of whom got the Gold Medal in the London M.B., the other three being—H. O. Brookhouse, W. H. Trethowan, and Ernest Wragg—probably no other batch of students starting at the same time has ever had such a record from any London Hospital or Provincial University.

Although we did not realise it at first it finally became evident that he was the best of them, nor did any of those who joined us from Oxford or Cambridge at the time he was in the wards come up to his standard, either in knowledge or as a clinician, with the possible exception of P. P. Laidlaw, although more than one of them attained an International reputation.

It is probable that from the first money was not abundant, for having been awarded a gold medal for anatomy in the M.B., and having got through the primary fellowship in November, 1903, he resigned the rest of his appointment, which was then much prized, of student demonstrator of anatomy, and went into the wards in January, 1904, with a first Michael Harris and a second Junior Proficiency prize to his credit. He took the M.B. in May, 1906, with honours. He was a clinical in April–June, 1906 (during which time he won the Treasurer's Medal and Prize in Surgery), and A.H.S. in the succeeding three months; and then we heard that he was not applying for anything else because his uncle needed him in the family practice at Middleham, and, at a time when it seemed that any appointment was before him for the asking, he left Guy's for ever.

His pre-eminence was based on his power to acquire knowledge in any and every way—with his hands from a patient, with his ears from a lecture or the more informal teaching of a ward round or out-patients, and with his eyes from the written word—and to use it when he had it. He had a rounded, oval face with a knob on his forehead that we in our ignorance thought was due to frontal sinusitis. He stared at you through a pair of gig-lamps which made him seem at first almost stupid; but underneath that he bubbled over with a sense of humour that was at once more dry and more pawky than that of any Scotsman, as well as at times being unduly Rabelaisian.

The next time I saw him was in the summer of 1917 when we were encamped in the Wady Ghuzer near Tel-el-Fara. I had walked over to the neighbouring Field Ambulance to have a chat with the commanding officer and entering the mess took a deep breath and said, "Hallo, George!" When we had finished our talk the C.O. said to me, "I see you know that funny old G.P. that they have sent up to me." "Funny old G.P.," said I. "Do not worry about him. He will pick up field ambulance work in next to no time and be one of your best officers. And," I added, "he will become the life and soul of your mess and keep you all in fits of laughter." I did not see him on the advance from Beersheba but I did once come across this C.O. who told me I was quite right about him. He had picked up the work in no time so that he was one of the best men he had and was a treasure in the mess, especially when they were strained or tired.

And then one day he dropped into my office in Jerusalem. It was raining, as it can rain there, and we were still in summer kit. The water was pouring off his pith helmet on to his machintosh and thence on to the floor, and his bare knees were raw with wet. He could not wait, he said, as they had put him in charge of the camels and he had a lot of them outside. He had come to say good-bye as they wanted him at Middleham, and had applied for his release, so he was going home. I got the idea, that it was not so much his patients as the water works, the gas company, and the sewage disposal, all of which apparently he used to run and they had all gone wrong in his absence.

I saw him once more when he brought a relative to see me and sent me a lovely Wensleydale cheese when he got home. When staying near Richmond with a friend I got him to diverge a bit when we were out one day and to go along the Wensley dale so that we could drop in on "George" at Middleham; but, alas! he was not in. He wrote and told me he was out with a lorry in a neighbouring town bringing in for the winter his "children" by which he described his bees with, I suspect, a touch of sadness in his script, for he was fond of children and had none of his own.

These are but few memories of the man over the forty-three years since he left Guy's in 1906, yet each of them is typical and bears out what has been said of him in *The Lancet*.

To my mind his life bears out three principles. The first is that the greatness of Guy's depends not on us who have stayed there but on those who go out into the world. The next, that General Practice needs the best men—and George was the best one I have known—and finally, the importance of the hereditary practice. Under the new conditions that medicine is to be conducted we want to hold on to all three of these.

T.B.L.

Dr. William Johnson

DR. WILLIAM JOHNSON, M.C., M.D., F.R.C.P., of 26, Rodney Street, Liverpool, Physician to the Royal Southern Hospital, Liverpool, and to the Royal Liverpool Children's Hospital, died suddenly on Tuesday, March 15th, at his home, "The Acres," Heswall, at the age of 63.

The son of the late Mr. and Mrs. W. E. Johnson, of Gwern Alyn, Wrexham, he was born at Wrexham on September 3rd, 1885, educated at Grove Park School, and received his medical training at Guy's Hospital, London. He qualified as M.R.C.S., L.R.C.P., and M.B., B.S., London, in 1908, and proceeded to the M.D. in 1911. In the next year he became M.R.C.P., and was elected to the Fellowship in 1926. After qualifying he held many residential posts at Guy's Hospital, but his career as a consulting Physician was interrupted by the 1914–18 War, during which he served with the British Expeditionary Forces in France. He held the rank of Major, R.A.M.C., and was awarded the Military Cross. He wrote several papers on the Psychoneuroses of War, of which he had had exceptional experience in the field, and contributed a section of "Neuroses in France," to the "Official Medical History of the War" (1923). In 1921 he was appointed Assistant Physician to the Royal Liverpool Children's Hospital, and to the Royal Southern Hospital. He was appointed Lecturer in Clinical Medicine and Clinical Pædiatrics at Liverpool University, Consulting Physician to the Ministry of Pensions Hospital, and Physician to the Liverpool Eye and Ear Infirmary, and the Birkenhead Municipal Hospital, and the Royal Liverpool United Hospital.

He was also Chairman of the Liverpool Regional Children's Hospital Management Committee, and of the Liverpool Ambulance Committee. He was President of the Section of Neurology of the Royal Society of Medicine, and had served for two years as Censor (examination for Membership) of the Royal College of Physicians, London.

He leaves a widow, a son, and three daughters, the eldest of whom is Dr. Elizabeth Johnson—also one brother, T. P. Johnson, and three sisters, in Wrexham.

A Letter from Italy

The following was recently (and quite appropriately) received at Guy's :

To The Manager of the
First or Magior Ospital of London (England).
I write to this Capital for to asking, if is possible, a big favor.

In all country of Italy is not possible to find some good medicines against the *Amebiasi*, whom I was contract in Africa in the 1942.

In this years nobodi was able to cure me. Why? I don't no; but may be the Ospitals in Italy have not the suitable medicines; this is the true.

In this week I meet some goods doctors, so they say me: "You can tray to write in Englan, because in that country have the speciality against the *Amebiasi;* so now I am writting to you for to ask if is possible, for you to send me the suitable medicines, as I can to send you the cheque.

Do you understand? Excuse the my bad english, but it is long time I don't wrote in yours nice lenguage.

I waiting a your letter for the conferm or no if you can to send me comwthing.

Excuse the my big mistakes.

Keep the my best regards and Hello;

Sincerely yours truly
P—— M——.

The Steele Diaries—IV

PATIENTS

9th August, 1854.

Since 1st August there have been 16 cases of cholera admitted, of which number 2 have been discharged as cured, 11 have died and 3 remain in the Hospital. The two wards, John and Upper Petersham, have been set aside as Cholera Wards, the former for males, the other for females.

20th September, 1854.

Since the commencement of the Epidemic 102 cases of Cholera have been treated in the House, of which number 83 have been admitted with the disease, while 19 have been attacked in the Wards. Of the total number 38 have been discharged as cured, 57 have died, while 7 remain under treatment.

21st October, 1857.

I have to bring under your notice the death of a patient in Stephen Ward, said to have been caused by his having gin given him by his daughter on Friday last during the visiting hour. The patient's name, William Coles, admitted 14th October and died 19th October: cause of death reported in Pathological Register is "Chronic Hydrocephalus."

I have also to report other irregularities in connection with the transmission of contraband articles to the patients, chiefly due to the freedom of communication through the railings at the east side of the grounds. It has been suggested that the access to this part might be prevented by a dwarf railing from the New Building to Barnabas Ward, and by an intimation to the same effect.

11th November, 1857.

I have to notice a case of attempted suicide from swallowing opium which occurred in Luke Ward on Monday last. The patient states that he has been in the habit of secreting his opium pills nightly for months until they had accumulated to about 40 grains, and that he feigned swallowing them when administered by the Sister. On enquiry it does not appear that any blame is attachable to the Sister of the ward, as she has given the medicines regularly. The patient was dismissed from the Hospital yesterday.

25th November, 1857.

I have to report that Geo. Dyster, a patient in Philip Ward, admitted 9th September, accidentally met his death on 17th inst. by falling down the main staircase of the building. At an inquest held on the body on Thursday last, the Jury returned a verdict of accidental death, animadverting at the same time on the conduct of the Sister of the ward who had neglected to call in medical aid at the time of the accident.

6th January, 1858.

I have to submit the following case with the view of instruction as to whether any further proceedings should be taken in connection with it. A young woman aged about 18 and apparently a servant girl, was brought to the Hospital on Saturday night last from the Brighton Railway Station, in an insensible state. On inquiry it is ascertained that she was placed in the railway carriage at Portsmouth and instructions were given that she should be sent to her friends in London. She is now in Lydia Ward and is evidently suffering from a very bad form of Fever.

13th January, 1858.

Number of Women delivered during the year—1,731. Number of single Births—1,714. Twin Births—17. Total children—1,748.

Of the 1,748 Births 889 were living males, 773 were living females; 56 were males stillborn and 30 were stillborn females. Of the total number, 1,683 presented naturally while the remainder, 65 in number, were abnormal presentations. Of the latter there were 31 Breech, 18 Footling, 6 Arm, 5 Face, 3 Funis, 1 Transverse, and 2 placental presentations. Among the mothers there are only 2 reported dead, 1 from uterine hæmorrhage and 1 from puerperal peritonitis. Of the 1,731 mothers, these were in their—

1st	Confinement	254	7th	Confinement	130
2nd	,,	279	8th	,,	86
3rd	,,	242	9th	,,	56
4th	,,	210	10th	,,	53
5th	,,	191	11th	,,	21
6th	,,	166	12th	,,	20

13th	Confinement	5	17th	Confinement	3
14th	,,	7	18th	,,	1
15th	,,	3	20th	,,	1
16th	,,	3			

27th January, 1858.

I deem it my duty to bring under your notice the following unfortunate occurrence resulting in the death of a patient. A child aged about 4 years and suffering from Croup was admitted last week into the Clinical Ward and was subjected to the operation of Tracheotomy for symptoms of impending suppuration. While progressing favourably, it was attacked on Saturday morning last with the usual symptoms of choking, and the nurse finding herself unable to remove the instrument from the throat went immediately for the Dresser in charge. An inexcusable delay of nearly ½ an hour appears to have taken place before any one could be obtained, and when the Dresser at length arrived the child was too far gone to permit of resuscitation.

10th February, 1858.

I have to bring the following case under your notice. A person of the name of Elizabeth Clarke was discovered by the police in an insensible condition and brought to the Hospital on Monday night last. On inquiry it was found that she was suffering from starvation and cold, and that on application at St. George's Workhouse, to which parish she appears to have a claim, she was discharged on Monday forenoon without any relief. The patient was sent yesterday to the Borough Police Court that the Sitting Magistrate might deal with the case.

21st April, 1858.

I beg to bring under your notice the case of a man, Wm. Moore, admitted to Job Ward on 12th April, suffering from severe symptoms of chest disease. The patient ascribes his illness to the Sulphur Fumes emitted from Mr. Man's, hop and seed warehouse in the White Hart Yard, and which has also been the cause of much compalint by the workmen connected with the Hospital who have suffered in consequence of the proximity of the workshop to the source of the nuisance.

6th October, 1858.

I have to notice an outbreak of itch in Patience Ward and to recommend that the number of admissions be reduced until the disease is got under. The patients affected have been already separated as much as possible from the non-affected.

30th March, 1859.

In consequence of the want of accommodation in the ordinary Gangrene Ward and the occurrence of a severe case of gangrene in Naaman Ward, I was necessitated on Monday last to open John Ward for the reception of the case as well as for any others that might occur in the Hospital.

27th July, 1859.

I have to report the case of John Brook, patient in Stephen Ward, who attempted to commit suicide on Friday last. This man was suffering severely from Inflammation of the Lungs and took a razor with him into the watercloset where he severed all the large vessels at the bend of the elbow for the purpose (as he confessed afterwards) of putting himself out of pain. Although detected shortly after the act, and not losing more than 6 oz. of blood, the patient sank a few hours after the injury. At an inquest held on the body on the following day, the Jury returned a verdict of death from natural causes.

24th August, 1859.

I have to notice an outrage that took place this morning about 9 o'clock in Stephen Ward by a number of Irish people in the removal of the body of a man named John Donohue, who died there about 6 o'clock. The ordinary custom of the Hospital is to have the body of a patient conveyed to the dead house immediately after death, from whence it may be removed by friends in the course of the afternoon. In the case reported, the friends to the number of 20 appeared to have forced an entrance at the back gate and to have proceeded directly to the ward from whence they removed the body, notwithstanding the strong protestations of the Sister and the porters.

1st February, 1865.

There were 293 operations in the Theatre and Surgical Wards recorded during the year of which 66 terminated fatally.

The mortality in capital operations as in the previous year, 1,863 continues very high.

Of 7 cases of Ovariotomy, 4 died and 3 recovered. Of 12 cases of Litphotomy, 1 died and 11 recovered. Trephining and elevation of Depressed bone, 7 died and 2 recovered. Herniotomy, 19 cases, 11 died and 8 recovered. Ligature of larger arteries, 9 cases, 2 died and 7 recovered. Colonotomy or puncture of intestine, 1 died. Larger amputations, Thigh, Leg and Arm, 35 cases, 19 died, 16 recovered.

Correspondence

Lucretius Continued

SIR,—What things have we seen
Done at the Mermaid ! heard words that have been
So nimble, and so full of subtle flame,
As if that every one (from whence they came)
Had meant to put his whole wit in a jest.

To " B.D.J." and Mr. Geoffrey Hammond the habitation of the Mermaid will be plain enough ; and I am glad to see that the old spirit does not die. Such delightful verses as those of " B.D.J." remind one of the Baconian aphorisms about friendship, for example how friendship opens the understanding and how " a Man learneth of Himselfe and whetteth his Wits as against a Stone, which itself cuts not."

Mr. Hammond's bubble of a jest is the quaint insinuation that the medical student, notoriously a creature of delicate mind and tender conscience, might be affected in an unfortunate way by the doctrines of Epicurus. I need not take up his points in detail. I agree with him that a beginner needs a guide—but not a dogma ; that the search for the Epicurean " pleasure " is not a criterion—but such an impossibility was never suggested ; that the μονοχρονὸς ἡδονή, or pleasure of the moment, is a dangerous doctrine—but it belongs to Aristippus of Cyrene, not to Epicurus ; and that the gorging epicure of the Roman Empire is a disgusting figure—but he was not an Epicurean. I should like to draw attention to his interesting usage of assimilation, criterion assimilated to cafeteria and becoming criteria ; and finally to offer the suggestion that he has not studied Lucretius very deeply : in fact I am tempted to adopt the method of Mr. Pott and send him a copy of my article on the subject.

I must thank my two correspondents warmly for making known their views and for the urbanity, the almost affectionate grace, with which they have expressed them.

Yours, etc.,

H. St. H. VERTUE.

Larch Tree Lodge,
37, Tower Road,
Orpington, Kent.

SIR,—Surely in a lecture for graduates the speaker may rightly assume his audience have outgrown the early craving for the milky pap of dogmatic teaching and that it is hungry for tougher meats. Dr. Hammond complains that for meeting the problems of the management of healthy infants he is left lonely and without a guide. Should he go back and sit again at the Master's feet in the Centre ? He might, but this is not necessary for if, uncertain of himself, buffetted by these problems crowding in on him, he thinks on Vertue and murmurs " Te imitare aveo," he will hear a Voice guiding him. It is the Healthy Child telling him exactly what to do. " Feed me when I say I am hungry even if it is the middle of the night and the books say no night feeds ; pick me up and comfort me when I am lonely even if the dogma is that I should be left alone between feeds ; offer me solids when I have teeth to bite with ; and later on, if I refuse cabbage and like to eat my custard with my fish, this is the diet and the way of eating that is best for me."

If Mr. Hammond fears that following Rabelais' rule will spoil the child, let him think on Clara Davis' experiment. For six months, healthy children of a year old were given the food they chose, as much as they liked. The food was placed around them—they had only to point at ice-cream, mince, butter, cereal, milk and so on. At the end of the period they were overhauled by that great pædiatrician, Joseph Brenneman, who said that he had never seen a group better either in physique or in behaviour. There are indeed a great many recent observations which show that indulgence in infancy promotes later good health, physical and mental. Which is just what Plato as well as Epicurus said a long time ago.

No Sir, Dr. Vertue's lecture was no Pandora's box, but a casket which, jewelled without, had within even more precious useful treasures.

I am, etc.,

Guy's Hospital, S.E.1. RONALD MACKEITH.

Candida

SIR,—Your contributor, " M.F.," treated us, in the last issue of the *Gazette*, to some forthright and unpatronising comments on the Theatre Club's production of " Candida." Thus far it made a pleasing change from the customary eulogies. It was therefore unfortunate that many of his remarks should be invalidated by an erroneous conception of the play, one which a study of the text would show to be fundamentally wrong.

There are passages in his criticism which prove him to be a theatre-goer of some experience—for it demands considerable experience to be able to appreciate the timing of an entrance or an exit—and I feel that his remarks are based on his theatre-going rather than on a knowledge of what Shaw himself wrote. " M.F." speaks of " the emotional conflict between the poet, the clergyman and his wife—all idealists in their different ways." No ! and again No ! The emotional conflict lies between the poet and the clergyman—Candida exists merely to stimulate it and would do so were she never to appear on the stage ; the idealism lies in the poet and in the clergyman—Candida shows no more idealism than does any other housewife with a family to care for and an adoring, adolescent admirer to appeal to her vanity.

It is for your critic to assess the adequacy of the characterisations, but let him remember, when he writes of the part that Candida plays, that the character of Morell is created for the audience before ever his wife appears on the stage ; it is created in his encounters with the secretary, with the curate and with his father-in-law. Let him remember, too, that the character of the poet is given in his first altercation with Morell and again in his conversation with Prossy, before Candida herself has said two words of any dramatic importance. Indeed, if your critic would go back to the book he would find that, in the first two acts, Candida plays about as active a part as do George and Margaret in another play with which we are all familiar. Were he to read the preface to " Plays Pleasant," he would find no mention whatsoever of Candida herself. And in the third act, we discover all the inconsistencies of Candida's character which make the part so difficult to act and so doubly difficult to produce for, when she has " innocently " incited the poet to an amorous dalliance along the garden path, when she has " unknowingly " thrown her husband into a rage of envy, she turns on them both and proceeds to tell them just what Shaw thinks of them.

No, sir, the theme of the play is the battle of ideologies between Marchbanks, the exponent of the Truth and Beauty school and Morell, the disciple of Sermons and Scrubbing-brushes. Everything else in the play should be, and is, subservient to this theme—must never obscure it. Burgess is there merely to incite the clergyman to righteous indignation, Prossy to show how attractive can be the philosophy of Christian Socialism in the mouth of an attractive philosopher, and Lexy exists as a sort of Greek messenger in nineteenth century garb, playing a part that is usually taken on the modern stage by the G.P.O. telephone.

Herein lies part of the secret of Shaw's success as a playwright—that he is able to invest such characters as these with all the attributes of life and laughter. And here lies the clue to Candida's role in the story—she must be mature enough to maintain a clergyman's affection ; she must be attractive enough to fire a poet's breast (and what woman could do so unwittingly ?) ; she must be competent enough to explain each to the other. She need be no more.

Touching on his remaining criticisms, it is perhaps unfortunate that lack of space obliged " M.F." to indulge in vague generalisations. Had he been able to expand on his mention of " under-acting in the Coward style," he might have promoted an illuminating discussion on the differences between under-acting and dramatic restraint.

He will doubtless have seen, during the past three years, at least two productions of " Candida " in the West End of London which convinced him that he is right in his point of view. But, Oh, how the play can be tortured and twisted in the name of the Star System, so that a talented actress, taking both Candida and the play on her own shoulders, turns Marchbanks into a foolish, prancing child, and Morell into a self-righteous bore, and leaves neither with anything but the bare script to stand on.

With Candida dominating the stage, gone is the mainspring of the play—the all-important contrast between the passionate ardour of the poet and the tortured constraint of the clergyman (under-acting in the Coward style ?). In return, we are given little besides a display of virtuosity which turns the closing scene into a hearty victory for Common-sense and the Home, instead of a tragedy of Youth and Folly.

Yours, etc.,

Guy's Hospital, S.E.1. MONTAGUE PAYNE.

Students' Health Service

SIR,—I shall be grateful for the opportunity to bring to the notice of students the following details about the Students' Health Service.

The primary object of the service is a preventive one. Students are examined as soon as possible after arriving in the Schools and at the same time an X-ray examination of the chest is made. Arrangements are also made for immunisation of those who are susceptible to diphtheria, and Mantoux tests are carried out. Advice is given at the time of the interview in connection with any complaint which is discovered while, by regular X-ray examination subsequently, it is hoped to discover pulmonary tuberculosis when it develops, at an early stage.

At the present time there is great difficulty in continuing the routine X-ray examinations because of the serious shortage of X-ray film; such small supplies as are available must be used for patients who are sick. However, arrangements have been made for a "mass miniature X-ray" set to be available during May when it is hoped to X-ray all students in the Schools.

In drawing up the terms of the Students' Health Service, the School Council agreed that no attempt should be made to undertake responsibility for the treatment of students except under the conditions described above. Nevertheless, it has always been customary for the facilities of the Hospital to be readily available to students who were sick. Before the introduction of the Students' Health Service this was afforded in a rather haphazard way and students' notes, as a result, were often less well-kept than those of the ordinary patient, sometimes to the disadvantage of the student. We therefore decided to hold an Out-Patient session at which students might attend for advice, either at the recommendation of their own private practitioner, or at the instance of their teachers, or because they felt that they had some problem about which they would like help. From this Out-Patients the student was referred whenever necessary to various members of the Visiting Staff for further opinion and for treatment.

Even these arrangements do not meet all the difficulties, for the student suddenly taken ill or suffering from an injury might require immediate attention. In such cases he went to the Front Surgery and was afforded relief. Lately the number of students attending the Front Surgery for advice and treatment has considerably increased and includes a large number suffering from minor complaints or wanting advice which could better be given at Student Out-Patients which is held every Wednesday. As a result of this, there have been occasions when the busy work of the Surgery has been held up. The Superintendent and the Dean have therefore agreed that students who require immediate advice which cannot be dealt with at the forthcoming students' Out-Patient session, might attend the Surgery between the hours of 9.0 a.m. and 10.0 a.m. Students will not ordinarily be seen except in cases of emergency at any other time in the Front Surgery.

I am sure that students will realise that by keeping to these times, the O.P.O. will be able to see them without undue delay and at the same time the work of the Surgery, dealing as it does often with serious illness, will not be impeded.

I am, etc.,

Students' Health Service,
Guy's Hospital, S.E.1.

W. N. MANN.

"Vitiligoidea"

SIR,—Passim of 26th March gives credit to Addison for the joint authorship with Gull of the paper entitled "Vitiligoidea," in which the condition now known as xanthomatosis was first adequately described. This paper was, in fact, entirely the work of Gull, although it appeared under the name of both men. The Sydenham Society's collection of Gull's writings draws attention to the following note which was found after his death:—

"This paper I wrote entirely. . . . When the paper was finished I asked the favour of Dr. Addison to let his name appear with mine at the head of the communication, which he did. My request was on the ground of gaining authority for what I had written, and I was then working with Addison, who saw the cases with me."

Models of some of the cases described by Gull in this paper are still preserved in the Gordon Museum.

Yours, etc.,

Guy's Hospital, S.E.1.

G. L. L. REYNOLDS.

Reviews

Diseases of the Nose and Throat. By Sir ST. CLAIR THOMSON and V. E. NEGUS. 5th Edn. Cassels. *Price* 70*s.*

WHENEVER something is eagerly anticipated for a long time there is a risk that its ultimate realisation may prove an anti-climax. The appearance of this edition of a book, for years established as a classic, has been greatly delayed, but the many who have looked forward to it should find no cause for disappointment here. Mr. V. E. Negus was unhappily deprived of the help of his famous collaborator when early in 1943 Sir St. Clair Thomson died, but the features with which Sir St. Clair stamped his book a masterpiece have been faithfully preserved.

An appendix to the preface lists the major alterations which are more considerable than previously. *Besides being a standard work of reference this book is, we believe,* the best text available for the post-graduate student.

L.F.W.S.

Joseph Lister : The Friend of Man. By CHARLES CAMERON. Heinemann. *Price* 17*s.* 6*d.*

IT is very right and proper that we should know something of Lister. Before him, surgery was the surgery of the Steele Diaries. Because of him, surgery became the surgery of to-day. Dr. Cameron has made what is very right, very very enjoyable, and has proved himself as good a raconteur in print as we know him to be by the fireside, the bedside or the table after dinner with the chairs pushed back. This story of the greatest man in British Surgery is so colourful, so sympathetic, so readable and smacks so of the truth, that it is difficult to put down. It can be recommended without reservation not only to everyone in the medical and nursing professions, who ought to read it, but to anyone without, who has any taste at all for the romance of experiment and discovery or the history of humanity in recent times.

H.A.R.

Changing Disciplines. By J. A. RYLE. 1st Edn. Cumberlege, Oxford University Press. *Price* 12*s.* 6*d.*

SINCE the heyday of Greece the relationship of environment to disease and the pursuit of positive health have been accorded progressively less attention. Clinical medicine has been taken too literally. The student spends his preclinical years in laboratory exercises and then proceeds to the study of "cases" in hospital isolation with almost scientific detachment. No simple adjustment to the medical curriculum can foster a wider appreciation of the social factors involved in causation and treatment. Nevertheless, the preliminary clinical appointment—a most valuable three months—might well be extended beyond the confines of instrumental manœuvres and elementary pathology to a consideration of the wider social aspects. "Changing Disciplines," by Professor Ryle, renowned both as an established Guy's clinician and an authority on social medicine, would then prove an invaluable text. Though constituting no more than a resumé of the subject it is good enough (and brief enough) to be read by everyone about to enter the wards. Others, too, will find in it many useful suggestions and thought-provoking ideas.

Guy's Diary

APRIL

ACADEMIC

Exhibition. Surgical Dept. "Osteomyelitis."

11th. 3.30. *Dr. Barber and Dr. Forman.* Demonstration of Skin Diseases. Preclinical Classroom.

5.00. Dr. L. G. Scott. Dept. of Child Health. Postgraduate Lecture. "*Neonatal Infections.*" Preclinical Classroom.

12th. 1.00. Sir Heneage Ogilvie. Clinical Lecture. "Surgery in Cape Town."

14th. 4.30. X-Ray Meeting. Gordon Museum.

18th. 5.00. No Postgraduate Lecture. Dept. of Child Health. Preclinical Classroom.

20th. 2.00. Dr. Marston. Postgraduate Revision Lecture in Anæsthesia. Clinical Theatre (Surgical Block).

21st. 1.00. Mr. Glover. Clinical Lecture. "*Surgery in America.*"

4.30. X-Ray Meeting. Gordon Museum.

22nd. 1.00. Dr. Holling. Clinical Lecture. "Peripheral Vascular Disease."

2.15. Medical Dept. Combined Round. Preclinical Classroom.

23rd. 10.00. Surgical Dept. Clinico-Pathological Meeting. Anatomy Theatre.

25th. 3.30. Dr. Barber and Dr. Forman. Demonstration in Skin Diseases. Preclinical Classroom.

5.00. Dept. of Child Health. Postgraduate Lecture. Preclinical Classroom.

Sport

ASSOCIATION FOOTBALL

INTER-HOSPITALS CUP FINAL

GUY'S *v.* MARY'S (Holders)

Won 1—0.

30th March, 1949.

The Association Football Cup returned to Guy's after a lapse of two years, when with but two minutes to go in extra time, the all important goal was scored. It was a most exciting and close struggle which kept both teams' supporters on their toes right until the finish.

In the main both defences proved too strong for the opponent's attack, which speaks volumes for Guy's when it is remembered that Mary's had Kelleher, this season's Irish International skipper, and member of the British Olympic XI, and Sullivan the Welsh Soccer and Rugger trialist in their forward line.

There were numerous near misses at both ends. Fearn, who was very safe all through, made two brilliant saves in the opening half, whilst Howells somehow managed to hook a Sullivan header off the goal line when all seemed lost. Both Lewis and Sturdy had good efforts blocked and a long range free kick from Lipington was headed off the line.

The second half found Guy's dominating the mid-field play and but for tardy shooting and ill-directed centres goals must have come, as it was, only two minutes of extra time remained when this superiority brought its reward. Sturdy fastened onto a loose ball and veered to the right wing. He crossed a curling centre which the Mary's 'keeper failed to grasp cleanly. Lewis pounced on the ball, shot it goalwards and Oldfield made quite certain that it was a goal.

There was very little time for Mary's to recover, so Guy's had no difficulty in holding on to their lead, and amid much excitement Matthews (our captain) received the Cup from the President of Mary's A.F.C. (Dr. G. W. Ellis, O.B.E., D.Sc.).

All the Guy's defenders played magnificently to put up their best performance of the season.

It is invidious to mention individuals in such a well knit defence built around centre-half Young, but perhaps the biggest bouquet should go to Swift who had the hardest task and succeeded splendidly in mastering the redoubtable Kelleher, although he would be the first to acknowledge the assistance he had from inside-left Prince, who played a grand game both in defence, and in initiating attacks. Sturdy was a live-wire in the attack, but once again I must affirm that it was team work which brought the Cup back to Guy's.

Team : A. Fearn, D. Lipington, W. Howells, D. G. Matthews, J. F. Young, P. A. Swift, J. C. Leckie, D. E. Sturdy, N. I. Lewis, A. G. Prince, D. L. Oldfield.

Congratulations to the above and also to R. Skaith and E. Newton who assisted in previous round matches.

FENCING

The Spring term opened badly, with defeats for both the first and second teams which resulted in our elimination from the Inter-Collegiate Foil Championship organised by the University Club.

But our period of reverses came to an abrupt end on 24th February, when we defeated the Depot, Royal Marines, Deal, by 18 fights to 9, and this was followed on 11th March by a 19—8 victory over the Old Cooperians.

On 21st and 22nd March, a touring team from Edinburgh University held a meeting in the Pavy Gymnasium. On the first day a triangular match between London, Edinburgh and Cambridge Universities was won by London with Cambridge second; Wilson, Conran and Scott of Guy's Hospital, were fighting in the London team. On the second day, Guy's beat Edinburgh in all weapons.

PRELIMINARY NOTICE OF EXHIBITION OF PAINTING BY GUY'S MEN

In June it is hoped to hold an exhibition of paintings by present or past Guy's men. Anyone who is connected with Guy's in *any* capacity is eligible to exhibit. Pastels, water-colours and oils, framed or unframed, will be accepted, but posters are excluded. They must be presented for hanging by June 1st, and all communications and enquiries addressed to Miss Tredgold, Dept. of Medical Illustration.

It is emphasised that all entries will be accepted provided that space allows. It is hoped that those who indulge in painting as a part time hobby will not be shy, as it is primarily for them that the exhibition is being arranged.

NINETIES CLUB

Union of "Goblins" and "Contemporaries"

The Annual Dinner of the above Club will take place at the Trocadero Restaurant, W.1, on Wednesday, May 11th, 1949, at 7 for 7.30 p.m., with Sir John Atkins, K.C.M.G., in the Chair.

Price of dinner £1 1*s.* 0*d.*, exclusive of wine. Will any who entered Guy's in the 'nineties, who do not receive through the post a notice of this dinner, and who would like to attend, please send their names and addresses to the undersigned.

E. B. DOWSETT.

12, Gloucester Place,
Portman Square, W.1.

THIRTY CLUB

The Annual Dinner of the Thirty Club will be held at the Trocadero Restaurant on Friday, May 13th, at 7.30 p.m. A personal letter will be sent to each member and it is hoped that there will be a large attendance.

RESULT OF B.M.S.A. REFERENDUM

March 14th–18th, 1949

For affiliation	.. ..	109
Against affiliation	..	160
Spoiled papers	.. ..	1
Total	..	270

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Assistant Dental Surgeon** to Guy's Hospital; attendance on two sessions per week with remuneration at the rate of £200 per session, subject to revision when the new Ministry of Health scales and salaries are published. The appointment is of consultant status. Applications (one copy), with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, by 27th April, 1949. In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, convassing of Members of the Board or Advisory Appointments Committee will lead to disqualification.

Applications are invited for the following posts commencing 1st October, 1949 :—

Dental Surgery
3 Half-time Assistants to the Director of the Conservation Room.
4 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.
1 Demonstrator for 1 session per week.
Administrative Dental Officer (Half-time).

Extractions and Minor Oral Surgery
2 Half-time Assistants.

Dental Mechanics and Prosthetics
2 Half-time Assistants to the Director of Dental Prosthetics.
2 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.

Dental Department for Children
1 Half-time Registrar (6 sessions per week).
2 Part-time Registrars for 3 sessions each per week.

Preventive Dentistry
1 Half-time Director.
2 Half-time Assistants.

Clinical Pathology (Dental)
1 Assistant Clinical Pathologist (Dental).

Special Anatomy and Histology
1 Half-time Demonstrator.

Form of application may be obtained from the Medical School Office and should be returned on or before Friday, 20th May, 1949.

RESIDENT MEDICAL OFFICER, NUFFIELD HOUSE

Applications are invited for the post of Resident Medical Officer in Nuffield House, duties to commence on Wednesday, April 13th, 1949; salary to be at the rate of £350 per annum with residential emoluments, subject to revision in the light of the Spens Report on Medical Salaries. Applications should be lodged with the Superintendent, Guy's Hospital, S.E.1, on or before Friday, April 14th, 1949.

PASS LIST

CONJOINT BOARD

L.R.C.P., M.R.C.S.

March, 1949.

Chemistry: K. E. G. Peters.
Physics: H. A. Hill, J. F. Wylie.
Elementary Biology: D. K. Hutchinson, K. E. G. Peters, J. T. Williams.

Anatomy.

C. O. Bedell	H. G. Carr
F. D. Burgess	M. M. Levene

Physiology.

F. D. Burgess	M. M. Levene

Pharmacology.

G. A. E. Baker	I. H. Maine
K. B. Bender	E. J. Masters
A. J. Bridge	N. M. Midgley
N. P. Bronsdon	J. N. Pachmayr
G. R. C. Deacon	P. L. Pelmear
A. Ferrari	P. J. Rademan
H. Gold	J. H. Ratcliffe
R. Goulding	P. W. Ruggles
H. V. Hoyle	F. B. Sartory
J. C. Jelleyman	K. A. E. Spence
P. H. Kendall	J. A. Thornton
P. J. Koblenzer	C. B. Vaughan
D. T. Lovell	L. Wollner
J. U. MacWilliam	I. J. P. Woodhouse

UNIVERSITY OF LONDON

January, 1949.

PH.D. EXAMINATION FOR MEDICAL DEGREES.

Faculty of Science.

M. E. Foss.

APPOINTMENT

D. G. Vulliamy, B.A., M.B., B.Ch., has been appointed Assistant Medical Registrar to the Hospital for Sick Children, Great Ormond Street, London.

PAPERS BY GUY'S MEN

Allsopp, C. B., and Another. The Action of Mustard Gas (B.β–Dichlorodiethylsulphide) on Living Cells in Vitro. *Cancer Research*, 1948, **8**, 145.

——, and Another. The Effect of Repeated Applications of Minute Quantities of Mustard Gas (B.β–Dichlorodiethylsulphide) on the Skin of Mice. *Cancer Research*, 1948, **8**, 177.

Baker, Charles. Wind. *Clin. J.*, 1949, **78**, 48.

Batchelor, J. S. Clearcot's Disease affecting both Knees and one Hip. *Proc. Roy. Soc. Med.*, 1949, **42**, 98.

Blaikley, J. B. Endometriosis of the Bladder: Tumour arising in Wolffian Remnants. *Proc. Roy. Soc. Med.*, 1949, **42**, 59.

Campbell, Maurice, and Hill, T. H. Angiocardiography in Congenital Heart Disease. *Brit. Heart J.*, 1949, **11**, 97.

Chapman, H. Orthodontic cases of Clinical interest. *Brit. Dent. J.*, 1949, **86**, 120.

Coxon, R. V. Some observations on Amœbic Dysentery. *J. Roy. Army Med. Corps*, 1948, **41**, 243.

Cutler, R. The Operating Headlamp. *Brit. Dent. J.*, 1949, **86**, 83.

Doubleday, F. N. On Local Anæsthesia. *Brit. Dent. J.*, 1949, **86**, 79.

Feaver, Roy E. Retained Deciduous Teeth. *Brit. Dent. J.*, 1949, **86**, 153.

Harley, H. R. S. Subphrenic Abscess. *Thorax*, 1949, **4**, 1.

Hardwick, C. Small Intestine Insufficiency. *General Practitioner*, 1948, **19**, 335.

Lloyd, N. L. Placing the Impaired Worker in Industry. *J. Royal Inst. Publ. Health and Hyg.*, 1949, **12**, 44.

Lubran, M., and Another. March Hæmoglobinuria. *Lancet*, 1949, **i**, 435.

Marshall, Geoffrey, and Others. Pneumoconiosis due to Graphite Dust. *Thorax*, 1949, **4**, 31.

Matthews, E., and Another. An Investigation into the Permeability of Human Deciduous Enamel. *Brit. Dent. J.*, 1949, **86**, 142.

Merrivale, W. H. N. Renal Function Tests in Pregnancy. *Newcastle Med. J.*, 1948, **23**, 143.

Mollison, W. M. Simple Ulceration of the External Auditory Meatus. *J. Laryngol, Otol.*, 1949, **63**, 85.

CHANGE OF ADDRESS

F. B. S. Barkworth, M.B., B.S., Oakhampstead, Dittons Road, Eastbourne. (Tel.: 1275.)

Paul, C. J. Crisp, L.D.S., R.C.S., "Dunclutha," Nyewood Lane, Bognor Regis (Surgery), and 10, A'Beckets Avenue, Aldwick Bay, Bognor Regis (Residence). (Tel.: Bognor Regis 996 and Pagham 233.)

J. G. L. Knowles, L.D.S., R.C.S., 57, Southborough Road, Bickley, Kent.

C. R. Neve, M.B., B.S., The College, Guy's Hospital, S.E.1.

MARRIAGE

RUSBRIDGER—WICKHAM.—On 12th March, 1949, at Kasama, Northern Rhodesia, George H. Rusbridger, of Exeter, Devon, to Barbara E. Wickham, S.R.N., of Wembley, Middx.

BIRTHS

FIGGIS.—On March 22nd, 1949, to Jean (née Hargreaves), wife of Dr. M. M. Figgis, of 36, North Side, Streatham Common, S.W.16—a sister for Felicity (Jacqueline Mary).

LEWIS.—On 19th January, 1949, at Nuffield House, to Bunty (née Moore), wife of T. L. T. Lewis—a son (Thomas Anthony), a brother for John.

MORTON.—At Craigernie, North Berwick, to Kathleen (née Russell), wife of Derrick J. Morton, M.B., B.Chir.—a daughter.

NANCEKIEVILL.—On March 18th, 1949, at the Jessop Hospital, Sheffield, to Dorothy (née Hesslegrave), wife of Leslie Nancekievill, M.D., M.R.C.P.—a third son.

PUSEY.—On March 26th, 1949, at Edgbaston Maternity Nursing Home, Birmingham, to Diana (née Moseley), wife of Roy F. Pusey—a sister for Richard.

ROSS.—On March 27th, 1949, at Nuffield House, Hospital, to Margaret (née Heath), wife of Allan Ross, B.D.S.—a daughter (Jacqueline Elizabeth).

DEATHS

CLOWES.—On February 25th, 1949, Norton Burroughs Clowes, M.R.C.S., L.R.C.P., of Dedham, Essex.

JOHNSON.—On March 15th, 1949, William Johnson, M.C., M.D., F.R.C.S., of Rodney Street, Liverpool, aged 63 years.

MYERS.—On March 25th, 1949, Anthony H. Myers, L.D.S., R.C.S., 42, Abbey Lodge, N.W.8.

STOKER.—On March 21st, 1949, at Guy's Hospital, George Morris Stoker, M.R.C.S., L.R.C.P., of 7, Streatham Road, Mitcham, aged 50 years.

Eds. {H.A.R. R. G.

GUY'S HOSPITAL GAZETTE

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PASSIM

" The singing masons building roofs of gold."—K. Henry V., I., ii.

SO impressive a structure was Guy's Hospital at its inception that the act of 1725 could refer to it as " a magnificent edifice, consisting of two spacious squares, with proper offices thereunto belonging." By 1939 the site had grown to about twelve acres in extent and on this area a vast array of buildings almost jostled for space. Six years of total war, however, left Guy's with renown and character undiminished but with fabric in obviously sorry plight. The havoc of direct destruction was serious enough. The inevitable neglect of otherwise essential maintenance work inflicted its further damaging mark. What a problem, then, faced the Governors at the end of hostilities! Buildings ill-designed for modern requirements and some of them even condemned before the war had to be adapted to changed circumstances, demands for painting and redecorating had to be met, provision for new developments in treatment, training and research had to be made, and all this with a strict control on raw materials, a dearth of skilled labour and an uncertainty as to the future.

To many people going in and out of the Hospital every day there is little evidence of the enormous material recovery actually achieved over the last three years. Yet an air of industry can be sensed, groups of workmen are to be seen about the place, heaps of sand, cement, bricks and timber abound, lorries and wheelbarrows are shunted across one's path and the sound of banging, scraping and drilling penetrates to every corner. For this reason, if for no other, some account of the progress made is given here.

Although to general regret the rebuilding of the east wing of Guy's House with the Governors' Court Room proved impracticable a temporary, pre-fabricated affair has been raised there which may not be very satisfying architecturally but which nevertheless serves a most valuable purpose as Sarah Swift Ward. Opposite, the erstwhile insignificant building which in the past has housed the Radiography School and various offices is being converted into a residence for the Superintendent.

In the small court to the left of the Colonnade the familiar " Round House " is being adapted as a central telephone exchange with a switchboard to be worked by three operators. Extensions will reach to all departments. The instruments, of standard design, will then allow for communication with the outside world through the G.P.O. network and inter-departmentally by an automatic dialling arrangement.

Hunt's House is the scene of many changes. On the ground floor the X-Ray Diagnostic Department is being reconstructed, re-organised and enlarged. A central records section has already been established. Six new X-ray suites will shortly be available, equipped with the latest devices and refinements. The old X-ray unit in Guy's House will in future serve only for surgical in-patients.

On the fourth floor of the Medical Block the accommodation for the new Deep X-Ray Therapy Department is practically completed. Immense structural alterations have been involved. Once the machines are installed treatment will be given to out-patients and to those in the medical and surgical wards. The unit at Pembury will remain for other in-patients. What was at one time the old private wing to the north of the tower has now been fitted up as sleeping quarters for night nurses.

In the old Pathology Block extra laboratories and a further animal house are to be set up. A new photographic department will be located there as well. The Students' Club premises on the first floor will thus be closed and shortly after Easter the new club-room in the College is to be declared open. The fire-place to be seen therein is of superb design and, interestingly enough, has been executed in stone salvaged from parts of the Hospital damaged by air-raids.

By York Clinic locker and changing rooms are being erected for the women students. Newcomen Street hostel exists as such no longer; the Psychological Out-Patient Departments will be found there in future. Perhaps conditions for psychological interview will be somewhat less distracting than they have been in the recent past.

By a process of gradual conversion over a number of years the electric supply to the Hospital is being connected to the A.C. mains. Intake will be through two 1,000 K.V.A. transformers already fitted up in the basement of Hunt's House and beneath the Nuffield Nurses' Home. The Dental Department, which has been re-decorated and re-equipped, is already linked to this new supply.

For a long time the Hospital chimney has been a cause for concern, not only to those living under its pall but to neighbouring interests and local authorities as well. A second boiler-house is being built on the bombed area by the Tabard and a further chimney is to be raised by the George. Automatic firing and efficient cleaning devices should then ensure complete smoke abatement within the next twelve months.

To make for better catering the kitchens have been enlarged and, under direct architectural supervision, laid out in an improved manner, while the Guy's shop has been overhauled and re-opened. In the wards, wireless receivers are fitted to all beds, with the exception of those in Victoria and Bright and Wilks where the delay is unlikely to be for more than a few months. By bedside control listeners have the choice of one of four programmes. The cost of this equipment was met by the Ladies' Association and also by the Theatre Club.

The new system of staff location by code lights, mentioned in the last issue of the *Gazette*, is working satisfactorily, though the warning panel in the Residents' Common Room gives every appearance of having suffered, and survived, "ordeal by fire."

Finally, many have wondered what all the excavations and scaffoldings to the west of the Colonnade presaged. A statue is being erected there in honour of Lord Nuffield. Readers of the *Gazette* in June, 1945, will recall that this idea originated with the late Sir Arthur Hurst. That the scheme is now being put into effect will be widely acclaimed.

But we have said "finally." There is in fact no conclusion to the activities of the architects and works department. Besides the notable undertakings listed here they are responsible for the numerous day-by-day services which are so essential to the functioning of the Hospital. In accord, no doubt, with present-day ideas all such efforts now come under the jurisdiction of a Planning Committee. Even before the main objectives are attained on the present site the attentions of this body will, one imagines, be concentrated on the new Guy's which we have seen as a model but which remains as a vision.

FOR a misprint in the obituary notice of Dr. George Cockroft (page 117 of the last issue of the *Gazette*) whereby "mildly Rabelaisian" was printed as "unduly Rabelaisian" we would ask our readers and the author to accept our unconditional apologies.

Holy Week and Easter, 1949

Many people remarked that they had rarely seen Guy's Chapel looking so beautiful as it did on Easter Day this year. Everything in it seemed to rejoice in the victory of our Lord's Resurrection. Our thanks are due to those who kindly gave flowers and also to those who so beautifully cared for and arranged them.

Special services were held throughout Lent and during Holy Week, and those on Easter Day were well attended. There was a service in every ward during the Festival. A large number of patients received the Holy Communion.

We were able this year for the first time to have two things which helped to point the meaning of the Resurrection. The Paschal (or Easter) Candle stands at the altar until Ascension Day, marked with symbols of the Five Wounds of our Lord's Body, and representing the Light of the Risen Christ dispelling the darkness of sin and death. The Candlestick was designed and presented by J. C. Whettam, Esq., A.R.I.B.A., of John Keeble Church, Mill Hill, in memory of his mother. We have also the Easter Garden which shows a representation of the Holy Sepulchre with the stone rolled away, revealing within the grave clothes and the absence of the Body of Jesus. Outside stands the figure of an angel. All round is the Garden of Joseph of Arimathea. We should be deeply grateful if anyone who reads this could send to the Chaplain moss, roots of small flowers, or rock plants so that we may keep the garden as long as we can. Not many grow at London Bridge.

Man and his Bowels

A Clinical Lecture delivered at Guy's Hospital, on January 27th, 1948, by T. L. HARDY, M.D., F.R.C.P., Honorary Physician, United Birmingham Hospital, Professor of Gastroenterology, University of Birmingham.

GENTLEMEN,—When your Dean did me the honour of inviting me to lecture at Guy's Hospital I was in some difficulty as to an appropriate title. I wanted to talk to you about the function and disorders of the colon, a subject of which he approved, but I realised that there had already been a wide use of adjectives and epithets, some critical, some compassionate, in relation to this unfortunate and, I fear, neglected organ. Thus Sir Arthur Hurst was wont to speak of "the sins and sorrows of the colon" and "the unhappy colon"; others have called it unstable, irritable and troublesome. My title "Man and his bowels" does at any rate emphasise the importance of considering the owner as well as his property, the whole being greater than the part. As a teacher and examiner it is my experience that the colon suffers from some neglect. We know a great deal more about the normal and abnormal physiology of the upper alimentary tract than we do about the lower. It is, perhaps, natural that we should take more interest in the intake of food and its digestion than we do in the humble function of its evacuation, and this is perhaps salutary, for we know how troublesome can be those who contemplate the lower bowel and its products too closely. To-day I want to consider the normal structure and function of the colon and rectum and those disturbances of function which lead to constipation.

Structure and function.

The colon extends from the ileo-colic sphincter to the pelvi-rectal bend, which leads into the rectum, and this in its turn ends at the very important anal sphincter. In my survey I shall include the rectum, whose functional integrity depends on the colon, as does that of the colon upon the rectum.

In structure as in function the colon has peculiarities, which are not met with elsewhere in the alimentary tract. Thus the longitudinal muscle is segregated into three bands or tæniæ which, being slightly shorter than the colon, produce a series of pouches or saccules which are present to a greater or less degree according to the tone of the longitudinal bands. The colon is an organ with a considerable degree of mobility. This applies to the cæcum, hepatic flexure, ascending colon and especially the transverse colon, which is very freely mobile and floats in the abdominal cavity at various levels according to the state of its contents, its activity and tone. Thus in the process of colon filling it may dip into the pelvis, while later it may be observed occupying a position at a much higher level. So great is this variation in position that there is rarely, if ever, justification in speaking of a dropped colon as an abnormality responsible for symptoms and none whatever for trying to prop it up with a belt. The position of the colon is determined by its functional activity, by the build of the individual, by his state of health and intra-abdominal pressure. A well-known Birmingham surgeon of an older day who was not too free with his aspirates was wont to say "Gentlemen, there is no more 'arm in a dropped testicle or a dropped colon than there is in a dropped 'h'." Only slowly, very slowly, do we learn the almost infinite variation of the normal.

The splenic flexure and descending colon are relatively fixed, while free mobility is again apparent in the pelvic colon which, when filled, lies in the abdomen and above the pelvic brim, falling into it after its contents have been emptied into the rectum. The rectum is fixed, and here the tæniæ come together and form a continuous coat of longitudinal muscle ending in the sphincter ani. The lumen of the bowel shows a general diminution from cæcum to sigmoid, but opens out again at the pelvi-rectal bend where the bowel makes an abrupt change in direction as well as calibre, but there is no sphincter here as was at one time thought. So much for anatomy.

The normal functions of the colon are the formation and transport of the fæces, the secretion of mucus and the absorption of water and electrolytes. In this lecture I am mainly concerned with the first of these two functions. The rectum completes the passage of the alimentary tract in the act of evacuation.

Colon filling or diastole.

The movements of the colon are decidedly mysterious, difficult to observe and difficult to understand. The general appearance is that of an impressive immobility

and the duration of passage of a barium meal many times that of its transit through the stomach and small intestine. The terminal ileum, that is the last 12", empties itself into the cæcum by a series of powerful mass contractions occurring every three to four minutes and dependent on gastric emptying, the gastro-ileal reflex of Hurst. Thus anything which delays gastric emptying such as pyloric obstruction will delay the entry into the cæcum, while pathological processes in the right iliac fossa such as appendicitis or Crohn's regional ileitis will delay gastric evacuation.

The cæcum as it fills undergoes a reciprocal relaxation, first described by Cannon, and it descends to a position in front of but not in the true pelvis. When filled it contracts slowly and almost imperceptibly on its contents and rises to its former level, the contents meanwhile filling the ascending and transverse colons, although very slowly. At this stage haustration, which is peculiar to the colon and which gives it its familiar segmented appearance, appears. The Latin word "haustrum" means an instrument for drawing water, the appearance of the haustrated colon being similar to the ancient string of buckets for drawing water from a well. There is some uncertainty as to the mode of formation of the haustra. I believe the correct explanation is that put forward by the American anatomist Lineback in 1925, namely that the circular muscle coat contracts segmentally to form the clefts and haustra, using the tæniæ coli as fixed cables to which to pull. The trefoil arrangement which results may be seen at times in X-Ray films of the colon taken under favourable conditions of filling. The purpose of haustration is to increase the surface of the colon for the absorption of water, and perhaps to grip its contents and as it were, squeeze them dry. The haustra do not move either in a proximal or distal direction, but as Hurst showed by taking films every few minutes and superimposing them, they may alter their shape, and so the colon contours, though very slowly. Haustration must not be confused with sacculation. Most books are very misleading on this point. The saccules are anatomical structures, more or less fixed; haustration is a physiological function associated with colon activity and analagous to the segmenting movements of the small intestine.

Colon filling appears to be entirely haphazard, though there are doubtless factors at present unknown which govern the process. With the collaboration of a number of medical students we observed colon filling by taking films every two hours over a 12-hour period at a variable time after a standard barium meal had been swallowed. There seemed to be neither rhyme nor reason in the results we obtained and there were almost as many variations as to the rate of passage, the time at which various landmarks were reached and the mobility of the colon as there were individuals. It follows, then, that to define the normal passage of the bowel contents in terms of the clock has no physiological sanction, whatever custom and civilisation have imposed upon us. The usual figure of 72 hours as the extreme limit of the passage of a barium meal in a normal individual is purely arbitrary.

Colon contraction or systole.

The emptying or systole of the colon is as dramatic and swift as its filling is featureless and slow. The movements of the one are too slow and the other too speedy and occasional for accurate study. Mass peristalsis was first described by Holtznecht in 1909. The movement is initiated by the gastro-colic reflex and occurs in response to the taking of meals. In most, but not all of us, it is conditioned to take place either on rising or immediately after breakfast. Suddenly, as one observes the colon, haustration disappears and the transverse colon becomes shortened, stretched and ribbon-like. Almost immediately, starting from an area of contraction usually just distal to the hepatic flexure, the entire contents of the colon are stripped forward into the descending and pelvic colon within a few seconds, the whole movement being without subjective sensation of any kind. Once, perhaps twice, or even three times a day the mass movement carries fæces into the rectum and initiates the call to stool. Whether this is the only method of colon peristalsis is not known, but none other has been recorded.

Defæcation.

The call to defæcate usually follows the mass movement, especially after breakfast, as the contents of the pelvic colon are forced into the rectum and cause the rise of pressure which initiates the mechanism. The act of defæcation consists of strong contractions of the rectum with synchronous relaxation of the anal sphincter. The act is started and reinforced by an increase of intra-abdominal pressure brought about by fixation of the diaphragm in the position of full inspiration and of the pelvic floor by the levatores ani, which also draw the anal canal upwards over the fæcal mass. The passage of fæces through the canal acts as a further stimulus augmenting rectal contraction and relaxation

of the sphincter. These physiological reflexes which are mediated through the nervi erigentes are made use of in clinical medicine by enemata which cause a distension of the rectal walls and so the expulsion of its contents, and by glycerine suppositories which have no action on the rectum itself but bring about defæcation by irritation of the mucous membrane lining the anal canal. This is the only part of the passage of the alimentary canal after deglutition in which consciousness is involved, though incomplete defæcation can take place through local centres in the sacral cord even in cases of complete transection at a higher level.

Nerve supply.

The mode of nervous control of the colon is uncertain. We know that the bowel possesses a considerable degree of autonomy, possibly responsible for haustral segmentation through the intramural nerve plexuses of Auerbach and Meissner. On the other hand tone and mass peristalsis, though maintained by the myenteric reflexes of Cannon, are clearly much influenced by extrinsic factors through the sympathetic and parasympathetic outflow. The distribution of these systems to the colon is uncertain, but it is probably safe to say that the nervi erigentes through the sacral outflow of the parasympathetic system are the motor nerves to the rectum and distal half of the colon. Stimulation of these nerves leads to increased movements, increased vascularity, enlargement of the folds and secretion of mucus. Sympathetic stimulation, on the other hand, produces in the main opposite effects ; relaxation of the gut, contraction of the blood vessels and a cessation of mucous secretion, but it must be remembered that the general effects of stimulation of the sympathetic nervous system are much less predictable than those of the parasympathetic.

Mucus.

Mucus is one of the most important secretions in the body and the principal line of defence and protection of any mucous membrane. The colon is richly supplied with goblet cells which secrete mucus in response to a nervous mechanism, but not to direct stimulation. Much of our knowledge of this fluid is due to important work done by Sir Howard Florey prior to his interest in penicillin. He showed that muscular contraction, increased vascularity and mucus secretion were the invariable response to stimuli of the nervi erigentes of the cat, whether the stimulus was applied direct or through the agency of cholinergic drugs or reflexly by stimulating the cut end of one nerve, the other being intact.

Mucus is a protective secretion in a very complete sense, and, mainly following Florey, we can summarise its activities as follows :—Mucus acts as the normal lubricant for the passage of fæces, and when these are hard is usually found adhering to them in small masses. It is poured out rapidly in response to irritation, chemical or bacterial, and protects the mucous membrane from direct injury. Purgatives form a good example of chemical irritation which produce an excess of mucus. Mucus dilutes irritants and interferes with the diffusion of substances from its surface to cell lumen, or may delay it sufficiently for evacuation to take place before injury is effected. The soap enema, or worse still, the turpentine enema will produce a considerable increase in mucus secretion and, in addition, marked hyperæmia and enlargement of the normal folds of the rectum and sigmoid may be observed on passing a sigmoidoscope. Mucus is conserved by the body and is very rapidly reabsorbed, so that normally only small quantities escape with the fæces, and it is due to the gospel so steadily preached by Hurst and his disciples that the practice of wilfully and wantonly washing mucus from the bowel has largely disappeared. Finally I would remind you that mucus alone, unaccompanied by pus cells or blood, is not evidence of inflammation, that is of colitis, but of irritation. All these effects are the result of local intrinsic stimuli. Exactly similar results may be seen in sensitive personalities as a result of emotional stimuli and account for some of the symptoms and signs which are characteristic of such conditions as the spastic colon, muco-membraneous colic and emotional diarrhœa, all of which are merely different aspects of colon neurosis. These activities of the colon are comparable to those seen in the stomach and so well described in the work of Wolf & Wolff on Tom as a result of over-activity of the cephalic parasympathetic or vagus nerve.

The absorption of water.

With the passage of the ileal contents into the cæcum the digestion and absorption of food products is complete apart from the partial and haphazard digestion of cellulose which depends on bacterial activity in the colon. The contents of the ileum as they enter the cæcum contain approximately 90 per cent. of water derived mainly from the intestinal secretions. As a result of absorption by the colon the water

content of the fæces is reduced to about 70 per cent. This mechanism is extremely important as a measure for conserving water and maintaining fluid balance. In febrile illnesses and other conditions associated with fluid loss and dehydration the resulting constipation is protective and must be respected. Purgation under these conditions may be hazardous and materially influence prognosis, a strange commentary on the evening purge and morning dose of salts which was the standard treatment for most medical admissions of my own day.

Disorder.

It is time now to pass from considerations of normal physiology to abnormalities of function which lead to disorder and give rise to symptoms. We can, for convenience, recognise two groups of such disorders—habitual or essential constipation, that is constipation occurring in a healthy individual without evidence of organic disease, and colon neurosis in which a functional disturbance of the colon is associated with bowel arrhythmia, various abdominal discomforts and evidence of emotional instability, inherited or acquired, in varying degrees of complexity. To-day I propose to speak only of constipation.

This is the simplest expression of functional disorder and may result from a failure in the colon, in the rectum or in both. May I, at this stage, make a strong plea that we should cease to define constipation in terms of the clock but rather in terms of physiological function? The passage of barium and other test materials such as dyes and glass beads show such individual variation as to make any definition based on a time factor wholly unreliable. As Hurst stated many years ago, " To have one action of the bowels a day is often regarded as the only normal condition, whereas it is nothing more than a question of convenience as it is found to suit the habits and diet of a majority of people." Bauer, a distinguished authority on constitutional disease, expresses the view that the chief causal factor of habitual constipation is the habit of defæcation at a certain time, mostly in the morning, mostly once a day and suppressing more or less unconsciously the desire to empty the rectum at other times. Such figures as are available dealing with the bowel habits of normal individuals suggest that approximately 60 per cent. of people have the bowels open once daily, 30 per cent. two or more times daily and rather under 10 per cent. less than once daily. It is my belief that this insistence on a daily action so beloved of our forefathers is little better than a tribal fetish, supported by much ritual observance and a singularly appropriate mythology. Conditioned reflexes have their disadvantages, they are easily de-conditioned. I have only to remind you of the havoc, chiefly mental it is true, which a change of diet, of occupation, of work, of climate or emotional stress may play upon the bowels of man. May I quote some words I have used on a previous occasion :—" I believe that education in bowel hygiene should teach that an action of the bowels once, twice or even three times a day is not abnormal and is in accordance with the gastro-colic reflex. No anxiety should be occasioned or suggested if the bowels are not open at the appointed time, nor must there be any neglect to open them at other times if the desire occurs. With change of scene, work or diet, in times of anxiety and fatique, a change of bowel habits is often natural and if this be realised and purgation resisted, adjustment soon follows." Let us abandon this time factor which has no physiological sanction and adopt a functional definition. Dr. Geoffrey Evans has pointed out that normal colon function is fulfilled with the passage of a formed stool, preferably soft, without discomfort or undue effort and accompanied by a sense of completion and satisfaction. I put it to you, what more could you wish, and if it occurs once a day, twice a day, every other day or even twice a week, what matter so long as it occurs.

Dyschezia.

Essential constipation may be due either to a delay in the passage through the colon or a failure in the mechanism of defæcation. To this latter type Hurst gave the name of dyschezia, or painful or difficult defæcation. In America they use the term proctogenic. There is little doubt that dyschezia is the commonest, and perhaps the primary cause of all forms of constipation. We have seen that defæcation depends on a sensitive local mechanism responding to a rise of intrarectal pressure, and on the integrity of certain muscle systems, the diaphragm, the pelvic floor and the abdominal wall. A failure in any one of these may result in an inability to empty the rectum ; thus dyschezia is liable to be found in young people, in women who have borne children and in elderly folk. In young people faulty training in early life, and particularly the encouragement of a faulty posture, are important initiating factors. The design of modern sanitary furniture is most unsuitable, particularly for children. It may be comfortable, it is

certainly not physiological. The proper position for defæcation is the squatting one which, though not elegant, is effective. The present construction of the lavatory seat makes a full use of the requisite muscles impossible. It needs to be lowered at least 4 ins. for an adult and more for a child. Neglect of the call to stool so that the rectum comes to tolerate ever larger quantities of fæcal material is another common cause. Inadequate facilities at school or factory, false modesty, the rushed and inadequate breakfast to catch the morning train or bus, the pace of modern life, all conduce to constipation of the rectal type.

In middle aged women, especially those who have been through difficult labour, the pelvic floor may be weak and the action of the levatores ani ineffective. Again in elderly people a weakness of the abdominal musculature or a failure of fixation of the diaphragm from chronic bronchitis and emphysema will produce a similar result. I would especially caution you in the use of barium meals in elderly people. The risk of impaction in the rectum is a very real one and in my opinion a barium meal or barium enema should only be given to elderly people if they are under supervision in the wards of a hospital. Finally dyschezia may be due to anal spasm from a fissure or other painful condition at the anal orifice. A careful inspection of the anus and a digital examination of the rectum are, of course, a sine qua non in the routine examination of a case of constipation. Never forget that if you do not put a finger in the rectum you will sooner or later put your foot in it.

The diagnosis rarely gives rise to difficulty. The rectum is usually greatly dilated and filled with a mass of hard fæces which have produced no desire for defæcation. At other times, although the rectum may feel loaded, attempts at defæcation are ineffective. A barium meal will show a normal passage through the colon to the rectum, which may be reached in 24 hours. There the barium collects, distending the rectal ampulla, and may not be passed for several days.

Colonic constipation.

Colonic constipation or an abnormally slow passage of the intestinal contents through the colon is in my experience a somewhat rare event. The entire colon is usually involved in the process and may remain filled for several days after a barium meal. When the rectum is finally reached defæcation is usually normal. On the other hand dyschezia is not seldom associated with a slow passage through the colon. The X-Ray appearances do not otherwise differ from the normal, and the old term "atonic constipation" is clearly a misnomer. Haustration is well marked and there is no greater tendency for these colons to be lower in position than those which empty in normal time. Myxœdema affords a good example of this type of constipation, and here the effect is doubtless due to deficient oxygenation; normal bowel action is readily restored with adequate substitution therapy. Colonic constipation is common amongst elderly people whose diet is inadequate in bulk to afford the normal stimulus. Defective peristalsis is also met with in conditions of dehydration where the conservation of water leads to abnormal dryness of the stools. On the other hand the most obstinate cases I have met with have been adults of good physique and normal musculature, and most of them, I am convinced, are psychogenic in origin. Many of them seem to have a pessimistic, defeatist attitude towards life, as one who might say "I cannot expect anything from anybody and therefore I do not need to give anything. I must hold what I have."

Mention must also be made of another type of constipation mentioned in the books, namely, spastic constipation. I am sure that it is better to regard this as one of the manifestations of colon neurosis rather than a form of essential constipation. It is by no means a constant feature, is more often alleged than actual and usually alternates with periods of diarrhœa, the essential functional disturbance being one of overaction. It would, I think, be better if the term spastic used in this sense was dropped altogether.

Treatment.

Essential constipation is usually symptomless and the patient consults you because he or she is worried about the constipation and not because he is ill. He is worried because he has been taught that good health depends on a daily action of the bowels and that if this does not happen he is likely to suffer from various symptoms due to poisoning from retained products, that is auto-intoxication. It is your duty to reassure him, after an appropriate examination to exclude organic disease, that constipation is little more than a harmless nuisance, that a daily action may be unnecessary and even unsuitable in his case, especially if obtained as a result of a purgative, that he is not suffering from any form of poisoning because his bowels are not open and that there

is no shred of evidence to show that constipation predisposes to cancer of the bowel or any other organic disease. It is a matter of interesting medical history that the protagonist and antagonist of the theory of auto-intoxication from colon stasis were both distinguished members of the staff of this Hospital. The argument was in full swing during my years as a medical student and hospital resident, and I do not propose to revive old controversy, but it is an ill wind that does nobody any good, and as a result we derived much valuable knowledge of colon function and the use of liquid paraffin as an emollient. The patient can be reassured that if his colon is as he supposes, a septic tank, it is a most efficient one and that the most certain way to cause trouble is to stir it up with a muck rake, that is a purgative. He should be informed that the organisms present in the normal colon are wholly beneficent, they digest cellulose with the liberation of products useful in stimulating peristalsis, they detoxicate many undigested end products, they synthesise certain vitamins and they do this work best when left alone. I must record my opinion that the attitude of the public towards these questions, and especially towards purgatives to-day is very different and much more healthy than it was ten years ago. I believe this is due in very large measure to the sound and constant teaching of Sir Arthur Hurst and his pupils on matters connected with bowel hygiene, though I think some credit must certainly be given to the radio doctor. It is true that certain symptoms such as headache, lassitude, a coated tongue and unpleasant breath may be associated with constipation, but it is now known that these symptoms are reflex in origin and arise from an over-loaded rectum. They can be reproduced by distending the rectum with tow and readily dispersed with an enema.

Having reassured the patient you will point out that the restoration of normal function will be a lengthy process and will demand his full co-operation. It is not my purpose to go into the details of treatment, but from what has been said of functional pathology the general principles should be clear. Regular habits of defæcation must be restored, and an attempt should be made to open the bowels after the main meals in tune with the occurrence of the gastro-colic reflex. A warm W.C., a crouching position for defæcation, or for elderly people, a stool for the feet must be insisted upon. Appropriate exercises for defective muscles must be planned, breathing exercises to improve diaphragmatic function, while for the abdominal wall some admirable exercises are described in a little book entitled " The Culture of the Abdomen," by F. A. Hornibrook. The pelvic floor must be restored, surgically if necessary, but the tone of the levatores ani may be much improved by the simple procedure of alternately contracting and relaxing the anal sphincter; an exercise which fortunately can be carried out without undue publicity.

The diet must be reviewed. It is perhaps a counsel of perfection to expect people to eat a leisurely breakfast in these days, but I have, nevertheless, been astonished at the number of working people who go without breakfast altogether; certainly the departure of eggs and bacon from the breakfast table has taken away much of the joy of the meal, nevertheless the stimulating effect of breakfast on colon function is not to be neglected, especially in those suffering from constipation. A sufficiency of roughage in the form of fruit, vegetables and some form of processed bran is essential, and often lacking in a modern dietary; so, too, is an adequate quantity of fluid, four to five pints in the day. Old people are particular offenders in this respect. Purgatives of the irritant type, and the most common are aloes, cascara, senna and phenolphthalein, must be given up altogether, though the weaning may have to be gradual. No treatment can be regarded as successful until the purgative habit is overcome for it is next to impossible to obtain normal colon function with their aid. Their place should be taken by an emollient such as liquid paraffin, or better by the so-called hydrophilic substances of which the best are those derived from psyllium seeds. These substances swell in water and add considerable bulk to the intestinal contents. They should be taken with plenty of water at meal-times. The best known one in this country is, I think, I-so-gel prepared by Allen & Hanbury. In all types of constipation, and especially in dyschezia, it is often necessary at first to open the bowel with an enema of normal saline or tap water, possibly after the fæces have been softened with olive oil. The quantity of fluid used should be gradually decreased until it can be dispensed with altogether. This is, I am well aware, a very superficial outline of treatment which may have to be planned and carried out in considerable detail, so that it is better to admit patients suffering from severe constipation to hospital, where they are subject to discipline and observation, and facilities are available for physiotherapy and dietary supervision.

Gentlemen, I am one of those who grasp with avidity any excuse for coming to London and this occasion has given me personally much pleasure and the opportunity of meeting you is one I greatly appreciate. I could not come to Guy's Hospital, parti-

cularly to give an address on any subject connected with the alimentary tract, without acknowledging my very great indebtedness to the writings, the personal inspiration and the friendship of the late Sir Arthur Hurst, one of the greatest physicians and certainly, I think, the greatest gastroenterologist of his time. Those of us whose interests lie mainly in the disorders of the digestive system must for ever remain in his debt. Hurst was a man with an international reputation, and it was delightful to see the affection and regard with which he was welcomed in medical centres on the Continent. I have heard him lecture in French in Paris and in German in Amsterdam, and in both languages with equal facility. He had a delightful sense of humour and many of us can recall the rather sepulchral chuckles with which he would greet a jest, especially if it had a slightly Rabelaisian twist. It is my belief that his work on colon and rectal function embodied in his book, "Constipation and allied intestinal disorders," published in 1921, is the best work that he did, and Dr. Henry Bockus of Pennsylvania, in his big three volume work on gastroenterology, describes it as one of the most complete treatises on the subject in the English language. I feel it will take its place in the select company of medical classics and remain as a memorial, not only to its author but also to this School and Hospital where the work embodied in it was carried out. I hope you will not think me presumptuous if I ask you to regard to-day's lecture as in some small sense an act of homage to his memory.

Reviews

Cunningham's Manual of Practical Anatomy. Vol. I. By JAMES COUPER BRASH 11th Edn. Cumberlege. Oxford University Press. *Price* 21*s.*

THERE can be few books used by medical students which have such a securely established place as this dissecting manual. To know one's Cunningham is, to all intents and purposes, to know one's human anatomy.

This volume has been very slightly reduced in size, and some excellent arteriograms included amongst the illustrations. Otherwise it is the same book as before, which we all ought to know.

Psychiatry—Theory and Practice for Students and Nurses. By H. C. BECCLE. Faber and Faber. *Price* 10*s.* 6*d.*

INTO this book of some 240 pages has been compressed C.N.S. anatomy and physiology, neurology, psychology, psychiatry and mental nursing. Written primarily for nurses studying for mental nursing examinations, it is more than adequate for this purpose. For the medical student it can be no more than a preliminary survey of the neuro-psychiatric field.

Lucid descriptions of the commoner neurological and psychiatric disorders are given. Treatment with E.C.T. (including the use of curare), prefrontal leucotomy and insulin shock are described.

It can be particularly recommended for nurses, and it may also be a useful summary for students.

S. H. B.

An Introduction to Cardiology. By GEOFFREY BOURNE. 1st Edn. Edward Arnold. *Price* 18*s.*

THIS book compares in size and price with Sir Thomas Lewis' Diseases of the Heart, and is intended for the same undergraduate audience. It is more richly illustrated with X-ray photographs and electrocardiograms, but the matter is presented with less clarity and there are defects of style which at times make for much confusion. Thus on page 38 the student is advised to measure the level of venous filling in the neck "above the level of the lower edge of the upper border of the mangbrium sterni." Here there is doubt whether the sternal notch or the angle of Louis is intended. And on page 188 the solecism is permitted: "A raised blood pressure may be found in conditions other than hypertension."

There is no reference to recent work and though this may be justified in an introductory book, the general impression is one of superficiality than of fundamentals.

"X.Y.Z."

Handbook of Surgery. By E. C. MEKIE and I. MACKENZIE. 2nd Edn. Livingstone. *Price* 20*s.*

HERE are 747 pages of packed surgical facts, with opinions expressed only when necessary. It is an exceedingly digestible concentrate, and withall well produced at a suitable size. This is a good book which merits wider recognition.

H.A.R.

Physical Signs in Clinical Surgery. Part IV. By HAMILTON BAILEY. 11th Edn. John Wright. *Price* 8*s.* 6*d.*

THE last part of this excellent book contains a description of the examination of the skeleton and peripheral nerves, amongst other things. It is as good as the other parts, which is extremely good, and for examination purposes probably even more valuable.

R.

EXHIBITION OF PAINTINGS BY GUY'S MEN

The organisers of the Art Show to be held in June are anxious to stress that entries are invited from Guy's women as well as men. The original notice may have failed to make this clear.

The Steele Diaries—V

PATIENTS—(*continued*)

7th November, 1866.

I have to report the suicide of a patient in Stephen Ward yesterday morning. The patient who occupied 32 bed and was suffering from phthisis got out of his bed and took possession of a bottle containing poison, which had apparently lain on the window sill for many months, the contents of which he poured into a mug and swallowed.

16th January, 1867.

The Operation List contains a total of 340 cases, of which 276 recovered more or less relieved, 5 were unsuccessful, and 59 died.

Among the more important operations there were 45 cases of amputation, excluding fingers and toes, of which 29 recovered and 16 died ; 9 cases of ligature of large arteries of which 6 were relieved, 2 were unrelieved, and 1 died ; 22 operations for stone in the bladder of which 17 were relieved, 1 was unsuccessful, and 4 died ; tracheotomy, 6 relieved and 4 died ; ovariotomy, 8 cases, 4 cures and 4 deaths. Among operations of unusual occurrence there were 1 case of excision of the knee joint, one of excision of the spleen, and one of gastrotomy, all these proved fatal.

30th October, 1867.

A patient on whom a Cæsarian Section was performed on Friday last died yesterday in a private room of the Clinical House. Neither the child, which is alive and healthy, or the body of the mother are claimed by friends.

8th January, 1868.

The number of surgical operations registered has amounted during the past year to 364 and the deaths to 67. These numbers present a considerable increase over the similar returns for previous years. 19 of the deaths from operation have been certified from post mortem examination to have been attributable to pyæmia but the mortality after operation, excluding several cases of unusual occurrence and special severity, has been rather less than in former years.

Among the special cases have been three double amputations, including both legs, thigh and arm, and right thigh and left leg, all fatal. Ovariotomy, 11 cases, the highest number ever registered, 6 cured and 5 died. Cæsarean Section , 2 cases, both dead. Lithotomy, 16 cases of which 15 recovered. Lithotrity, 3 cases, which have all done well. Tracheotomy has been fatal in 9 cases and successful in 4, while herniotomy has been attended with 14 deaths and 11 recoveries. 2 cases in which the intestines were opened to relieve the bowels (colotomy) were also attended with a fatal result. Excision of spleen died.

8th April, 1868.

I have to report the death, on the 6th inst., of a patient in Luke Ward from the inhalation of Chloroform, administered for the purpose of his undergoing the operation of colotomy. Patient was in a very weak, almost moribund, state, from not having taken food or drink for nearly 3 weeks.

21st October, 1868.

A complaint was made to me yesterday by the friends of a patient from Patience Ward, who was discharged on Monday in consequence of being pregnant. The complaint is to the effect, that the patient was discharged while in labour as she gave birth to a child shortly afterwards on London Bridge, and that she now remains in a critical state at her home in Hackney. It appears that the Surgeon saw her shortly before her discharge and recommended her to be sent away, but there is no reason to believe that anyone had an idea that the patient was in labour at the time of her discharge from the Hospital.

11th November, 1868.

An application is made by Mr. Bader for facilities to test the effects of nitrous oxide gas as an anæsthetic agent instead of chloroform. An iron bottle containing 15 gallons of the compressed gas may be obtained for £1. The Bichloride of Methylene which has been used for the past fortnight as a substitute for chloroform has not been found to possess the virtues ascribed to it and its use will be discontinued.

16th December, 1868.

I have to report two accidents occurring to delirious patients in the Hospital in the course of the week. On Thursday last, a man suffering from sloughing of the arm made his escape through the window of the watercloset in Mark Ward and died on the following day. Another patient in the Eye Ward who had recently been operated on for cataract, injured himself severely by attempting to get out of the ward and falling from the steps on to the pavement outside.

13th January, 1869.

The list of surgical operations (for the year 1868) includes 376 cases of which 62 proved fatal. The total number is considerably above the average of former years, while the deaths are 7 less than in 1867. The mortality though much the same as in the five years preceding 1867 presents a favourable aspect where contrasted with the smaller number of cases traated during the same period. Pyæmia as a complication has been noticed to prove fatal in 7 of the above cases, while chloroform as a cause of death is reported as having occurred after the division of a tendon. Among the more important operations are 3 double amputations of which 1 recovered and 2 died. In the fatal cases the operations were performed while the patients were in a moribund state to stop hæmorrhage. Ovariotomy was performed in 6 cases of which 2 recovered and 4 died, and colotomy or the operation on the large intestine to form an artificial anus was performed 3 times with 1 recovery and 2 deaths.

13th January, 1869.

The number of women confined through the agency of the Lying-In Charity has amounted during the year to 1,783, being 60 more than in 1867 and 200 more than the return from 1866. Among the mothers, 8 deaths are recorded, 3 of which are referable to puerperal fever, 2 from exhaustion consequent on hæmorrhage, 1 ruptured uterus, 1 peritonitis and 1 from pulmonary apoplexy. The operation of turning has been performed 14 times, craniotomy has been had recourse to in 3 cases and the application of the forceps in 9 cases.

14th April, 1869.

Mr. Bader made use of the new operating room on Monday last. There were present waiting for examination and operation about 20 out-patients with their friends, of these 9 had chloroform or other anæsthetic administered. There was considerable crowding in the staircase and private room and the space intended for patients recovering from the effects of chloroform immediately after operation was completely occupied with 6 patients placed on stretchers which had been borrowed from the wards. It will be necessary to have half a dozen stretchers for the especial use of the eye department.

7th September, 1869.

I have to notice a case admitted as an accident to Naaman Ward on Monday night, in which the Surgeon, a Practitioner at Woolwich, amputated the limb before forwarding the patient to the Hospital. As the circumstance is contrary to precedent it may be advisable to communicate with the gentleman, who is Surgeon to the Woolwich Arsenal.

17th November, 1869.

It was reported to me on Saturday morning, by the Sister of Patience Ward, that the child of the patient occupyihg No. 1 bed, of which she had been confined two days before, had died under somewhat suspicious circumstances during the night. It appeared that the child had taken food and was in an apparently healthy condition at 11.30 and that the nurse found it dead at 12 o'clock. The mother accounted for its death by supposing it to have got its head into her armpit while she was suffering from a paroxysm of coughing.

7th December, 1870.

Some alarm was caused on Wednesday last in consequence of a fatuous patient from Lazarus Ward, having left the ward without the knowledge of the Sister. He was discovered by the police on the following day to have been taken to St. Luke's Workhouse, from which he was removed by his friends.

28th December, 1870.

The ordinary Christmas fare of roast beef and plum pudding was issued to all the patients and servants on Monday last. It is feared that the unusual excitement consequent on the occasion was partly the cause of the sudden death of a patient in Philip Ward who was suffering from disease of the heart.

25th January, 1871.

The more important operations performed in the course of the year amounted to 345 and were attended with 63 deaths. This is a slight increase on the numbers of the preceding year, but is rather below the average of the years antecedent to 1869. Among the capital operations are 3 cases of colotomy of which 2 died, 4 cases of ovariotomy all of which were unsuccessful, 1 exploratory operation on the kidney for the relief of abscess in which the patient also died. Among the larger amputations, 19 were of the thigh of which 5 died, the 3 amputations performed immediately after injury being cured. One case reported of amputation at the hip joint for disease also proved fatal.

25th January, 1871.

The number of women confined during the year amounted to 2,183, of which 10 died from various puerperal causes. This is the largest number of women attended in labour from the Hospital since the Lying-In Charity was organised. The mortality among the women is considerably above the average of former years.

13th November, 1872.

It is very probable that in future Sulphuric Ether will be employed in the Hospital as an anæsthetic agent instead of chloroform. Its use will be attended with greater expense.

8th January, 1873.

The number of women confined and attended by Students at their respective homes amounted during the year to 2,518 against 2,240 in 1871, and a great advance in relation to the annual increase which has been going on for the last seven years.

Details of Midwifery Department and Women Confined :—

Single Births, 2,491. Twin Births, 27.		
Total Children		2,545
Living Male Children	1,285	
Living Female ,, ...	1,169	
Dead Males	53	
Dead Females	38	
		2,545

Of the above children 2,467 presented naturally at birth, 53 were cases of breech presentation, 7 were face, 16 were foot, 14 arm, placenta previa 2, transverse 2, and funis 2. Among the mothers there were 7 deaths attributable to the following causes : 3 to puerperal hæmorrhage, 2 to peritonitis, 1 to purpura, and 1 not stated but probably due to exhaustion.

19th March, 1873.

Another case of accident in a boy from ——'s Factory was brought in on Saturday and necessitated the amputation of the arm. Several cases of a similar character, where lads have been mutilated for life have been brought from the same source during the last few years, and are usually attributed to the same cause, a want of sufficient protection from the machinery.

As Others See Us

We publish, advisedly without comment but with acknowledgement to the Cleveland Plain Dealer, the following extract from an article which appeared in that paper on 8th January, 1949, from the pen of Philip W. Porter. After discussing the recommendations made to Congress by President Truman for a scheme of " health insurance " this contributor to the American paper went on to remind his readers of the dangers of " socialised medicine " in these words :—

" All you have to do is to see the way it is working out in Great Britain. I've lived over there and seen it function. Thank the Lord, I didn't have to depend on it, for I could go to competent army doctors. But I had plenty of friends who were forced to depend on it, for they had deductions for it taken out of their slim pay and couldn't afford to hire Harley Street specialists.

If what they got under socialised medicine was medical care and competent treatment of illness and disease, then I'm a Tanganyikan rhinoceros. The ' panel doctor's' office was an assembly line of 50 patients crowded into the time and space it should have taken him to handle 10. He gave each of them scarcely more than a look and a promise—and often they got the wrong medicine in the rat race. Some of the offices were even unclean and some of the doctors were smelling high of drink, but what did they care ? Their fees were guaranteed by the government at so much a head.

And the poor patient, if dissatisfied, couldn't change doctors once he had signed up, without the permission of the doctor he didn't like, or without three months for a government board to make up its mind. Meanwhile, he could make a choice between paying a competent specialist a stiff fee or dying slowly. One thing for sure, the socialised doctor would never cure him."

CORRECTION—Apologies are offered to Mr. Montague Rayne. His name, of course, should have appeared at the foot of the letter on the subject of Candida in the last issue of the *Gazette* and not " Montague Payne " as printed in error.

Correspondence

Founder's Day.

SIR,—The Board of Governors has decided that May 6th should be commemorated as **Founder's Day** by a service in the Hospital Chapel. The reason for choosing May 6th was that on that date in 1724 "thanks were given to Guy for his unparalleled bounty in gifts to this Hospital and in erecting at his own charge another Hospital for incurables."

Accordingly, on Friday, May 6th, 1949, at 1.15 p.m., there will be a short service in the Hospital Chapel. The address will be given by the Very Reverend H. A. Ashdown, M.A., Provost of Southwark Cathedral. It is hoped that as many people as possible will attend on this occasion.

Yours, etc.,
W. D. DOHERTY
Superintendent.

Guy's Hospital,
London, S.E.1.

Keeping Warm.

SIR,—In the first verse of the first chapter of the first Book of Kings it is written: "Now King David was old and stricken in years: and they covered him with clothes but he gat no heat." Again in Ecclesiastes 4—11 the preacher says: "If two lie together then they have heat: but how can one be warm alone?" To-day the answer to this question is probably a hot-water bottle or an electric heater. But warm-blooded animals have in their voluntary muscles a self-heating apparatus. These normally act as slow combustion stoves, but can function as immersion heaters. To get the best result the limbs should be flexed on themselves and on the body in order to lessen surface exposure. Then the most important groups of muscles should be tensed by acting against their natural opponents, which causes practically no movement of the parts concerned, and no disturbance of the bedclothes. It is surprising how soon one can warm up in this manner, and astonishing to find how few people know about it.

Yours, etc.,
RHODEL TAMU.

The Lister Carbolic Spray

SIR,—I remember the George Inn in the Boro' in the late eighties and early nineties, when I was a student at Guy's—and have often lunched and dined there. It was much frequented by members of the hop and hide trades which formed then as now, I believe, the staple industries of the Boro'.

In those days I was rather more addicted to conviviality than interested in archæology—nevertheless one of my memories in connection with the George may be worth recording.

About '91 an Irishman, a candidate for the R.A.M.C., who had come over to London for his exam., called on me with an introduction. He wished to see some surgery, and as that afternoon my chief, the late Sir Henry Howse, was operating, gladly accepted an invitation to be present. As a preliminary I brought him to the dear old George for lunch, at which he accounted for a glass or two of sherry, followed by a pint of very potent old ale, finishing up with a glass or two of port. I must add that I was much more moderate.

We then strolled round to Guy's where I introduced him to Sir Henry, who installed him in the front row of the theatre—set apart for distinguished strangers. One should mention that Howse used the carbolic spray while operating long after others had discarded it. It occasionally half-poisoned the assistants and doubtless was somewhat depressing for the patient. Anyhow it often caused us dressers to feel very wonky indeed.

Well, in the middle of the operation the theatre was startled by a loud snore from my Irish friend who was seen to be fast asleep. He woke with a start, smiled blandly all round and the work was resumed. Afterwards I asked him what he thought of the operation.

"Bedad," says he, "not much, for owing to the soporific effect of that damned carbolic spray, I could hardly keep me eyes open."

Oddly enough he appeared to have no idea that our lunch in the George was in any way responsible for his somnolence!

Yours, etc.,
R. H. HAYES.

Courtlands Hotel, Hove.

Tug-of-War

Last week an old tradition was revived when Dr. Boland's firm [challenged Sir John Conybeare's firm to a tug-o-war in the Park.

Before the war medical firms were frequently to be seen tussling against each other and against surgical and dental teams. The victors used to meet at H.O.P. when the Guy's Sports were held.

This, though an isolated "tug," was no less desperate in character. With the spring sunshine pouring down upon them (and perspiration pouring from their brows) the two teams tugged and tugged until by two pulls to none, Dr. Boland's firm won the day.

To the many onlookers it was a fine sight to see Honoraries, Registrars, House Physicians, Ward Clerks all pulling together—"officers" indeed "hauling and drawing with the mariners" in a style which would have delighted Nelson himself. And so great must have been the upset to their fluid balance that one dreads to think of the result had not some thoughtful "mariner" provided some trays full of mugs charged with suitable "fluid" for their immediate refreshment.

Guy's Diary

APRIL—MAY

April
Exhibition. Surgical Dept. "Osteomyelitis."

25th. 3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Dr. Polani. Dept. of Child Health. Postgraduate Lecture. "Perthe's Disease." Preclinical Classroom.

26th. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.

27th. 2.00. Dr. Marston. Postgraduate Revision Lecture in Anæsthesia. Clinical Theatre. (Surgical Block).

28th. 1.00. Mr. Eckhoff. Clinical Lecture.
4.30. X-ray Meeting. Gordon Museum.

29th. 2.15. Medical Dept. Clinico-Pathological Conference. Pathology Lecture Theatre.

May
Exhibition. Surgical Dept. "Swellings of the Neck."

2nd. 12.00. Surgical Staff Conference. Clinical Theatre.
1.00. Dr. McKeith. Clinical Lecture. "Intestinal Worms."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

4th. 2.00. Dr. Marston. Postgraduate Revision Lecture in Anæsthesia. Clinical Theatre (Surgical Block).

5th. 1.15. Founders' Day Service—Chapel
4.30. X-ray Meeting. Gordon Museum

6th. 2.15. Medical Dept. Combined Round. Preclinical Classroom.

9th. M.R.C.P. Course Commences.
1.00. Mr. Atkins. Clinical Lecture. "Endocrines and Carcinoma of the Breast."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

Sport

HOCKEY

THE FOLKESTONE FESTIVAL

RESULTS

v. **FOLKESTONE OPTIMISTS.** Lost 1—4.

v. **DEAL H.C.** Won 2—0.

v. **VICTORY, ANTWERP.** Won 1—0.

v. **SOUTH SAXONS.** Drawn 1—1.

The Folkestone Festival was a great success and was held in glorious weather. The performance of the Guy's team was a credit to the Hospital and with a little more luck (and perhaps a little more sleep!) they might have won three instead of two of their four matches. It may not perhaps be generally known that this is an "invitation" festival, Folkestone being the senior of the Easter Hockey Festivals.

In an exceedingly fast game against the Optimists, Guy's were beaten by the better team but had the finishing of the Guy's forwards been a little better the score might have been very different. As it was, Opie was unlucky only to hit the post with a fine shot. The tackling throughout, however, was good, sometimes bordering on the heroic.

In the game against Deal the many good passing movements resulted in a well deserved win. In the second half Guy's gained the upper hand and many times nearly increased the score.

The win over the Victory H.C. Antwerp team was a win over (on paper) a better team, and our success surprised everyone except ourselves. In a somewhat scrappy game the tenacity of the Guy's team and the soundness of its defence were more than a match for the élan of the Belgians.

Against our old rivals the South Saxons the Guy's team deserved to do better. The game was very fast, the quality of the hockey good, but perhaps incidental injuries or perhaps playing on the centre pitch before a considerable crowd seemed to prevent Guy's ever really settling down.

It would be invidious to mention individuals—everyone had good days and some played excellently throughout, but it was the Guy's defence which drew the greatest admiration of the onlookers—most of them hockey players themselves.

As a hockey tour, a holiday and a party it was a tremendous success and great credit is due to "Buster" Murray who as captain and organiser contributed so much to it.

Team: E. A. Murray (Capt.), G. H. Danford (Sec.), D. Sonnenfeld, C. Robinson, L. Mackey, R. Hodson, C. H. Opie, S. Earl, H. Meyer, D. V. Duckworth, C. Bishop, W. E. Dobson-Smyth.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the appointment of **Assistant Dental Surgeon** to Guy's Hospital; attendance on two sessions per week with remuneration at the rate of £200 per session, subject to revision when the new Ministry of Health scales and salaries are published. The appointment is of consultant status. Applications (one copy), with the names of three referees, should be submitted to reach the Superintendent, Guy's Hospital, S.E.1, by 27th April, 1949. In accordance with Statutory Instrument No. 1416 of the National Health Service Regulations, canvassing of Members of the Board or Advisory Appointments Committee will lead to disqualification.

Applications are invited for the following posts commencing 1st October, 1949 :—

Dental Surgery

3 Half-time Assistants to the Director of the Conservation Room.
4 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.
1 Demonstrator for 1 session per week.
Administrative Dental Officer (Half-time).

Extractions and Minor Oral Surgery

2 Half-time Assistants.

Dental Mechanics and Prosthetics

2 Half-time Assistants to the Director of Dental Prosthetics.
2 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.

Dental Department for Children

1 Half-time Registrar (6 sessions per week).
2 Part-time Registrars for 3 sessions each per week.

Preventive Dentistry

1 Half-time Director.
2 Half-time Assistants.

Clinical Pathology (Dental)

1 Assistant Clinical Pathologist (Dental).

Special Anatomy and Histology

1 Half-time Demonstrator.

Forms of application may be obtained from the Medical School Office and should be returned on or before Friday, 20th May, 1949.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Mr. R. J. Cann has been elected a fellow of the college.

APPOINTMENT

B. Lawson, F.R.C.S.E., D.A. Eng., appointed Surgical Registrar, Southern Hospital, Dartford.

CONJOINT BOARD PASS LIST

D.O.M.S.

P. L. Blaxter

D.C.H.

L. G. Scott. D. Q. Trounce.

ROYAL COLLEGE OF SURGEONS OF ENGLAND PASS LIST

L.D.S. FIRST EXAMINATION.

March, 1949.

Anatomy and Physiology.

A Allison
D. E. Blake
E. F. Bosson
L. R. Bromwich
J. M. G. Cameron
F. L. Coker
G. H. Danford
P. D. Daw
P. N. Dawson
K. R. Dixon
M. F. Dixon
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BIRTHS

TAYLOR.—On March 4th, 1949, at Nuffield House, Guy's Hospital, to Mollie (née Edwards), wife of the Rev. M. G. Glemm Taylor, M.A.—a daughter.

VULLIAMY.—On March 30th, 1949, to Daphne (née Gould), wife of Dr. D. G. Vulliamy, of Meadow Cottage, Charles Hill, Elstead, Surrey—a son.

DEATH

WACHER.—On April 11th, 1949, after a long illness, Harold Wacher, M.D., of Eddington House, Canterbury.

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PASSIM

IN the academic year 1938–39, some time before the B.M.S.A. was born, six years before the publication of the Report of the Inter-departmental Committee on Medical Schools, and nine years before the Oxford Conference held under the auspices of the Nuffield Foundation, Dr. G. A. M. Lintott, at the instance of Dr. Boland, started the Student Health Service at Guy's. During the war years, on account of student dispersal and other evident difficulties, full operation of the scheme was interrupted, although as much as possible was continued. In 1945, the complete service came into effect again. Of the earliness of its inception, and the use which has been made of it by other schools, inaugurating similar services at later dates, we may well be proud. One would expect to be more than satisfied with it when one bears in mind the quality of the late Dr. Lintott—a man so evidently equipped with the imagination to design such a machine, the energy to construct it, and with feet sufficiently firmly planted on the ground to crank it and see that it could be made to work. The fact that Mann could write in 1948 (G.H. Reports) that " in two and a half years, five students at Guy's have been discovered to be suffering from pulmonary tuberculosis at an early, usually asymptomatic and probably curable stage," alone justifies the time and money expended on the whole service.

It is not enough, however, that those who have laid down and developed the scheme should have known what they were about. That the machine should work efficiently and successfully to no small extent depends on the intelligent co-operation of those who partake of the advantages which it offers. The service does not attempt to undertake the day-to-day treatment of sickness among undergraduates of the hospital, and any attempt to foist such duties upon it will only encumber it in the performance of its proper task. Its aim is to correct existing disease of the more long term variety, for which the student either unsuspecting or complaining has not sought advice or is not receiving treatment, to prevent such diseases as are amenable to preventive measures, and to give advice to students, when required, on health matters. For example, a student with a sore throat may, as Dr. Mann pointed out in a letter to the *Gazette* on April 9th, attend the Front Surgery between the hours of 9.0 a.m. and 10.0 a.m. on any day. If, however, he has two or three sore throats in a winter, he is well justified in seeking advice at the Students' Out-patients held every Wednesday. But this is the least important aspect of the scheme, for after all, as with any other citizen, such eventualities are catered for without the Student Health Service. The important object is a preventive one. On admission to the Schools every student now undergoes a routine examination and a chest X-ray, and where deviations from the healthy normal are found, or where Schick and Mantoux tests indicate susceptibility, advice, treatment or immunisation are offered. Thereafter, at regular intervals, X-rays of the chest are taken, to lay that greatest of all student hazards, tuberculosis of the lungs.

This is a very great and important service. Elsewhere in this issue we have no hesitation in affording considerable space to a notice about the mass miniature radiography which is shortly to take place at Guy's, because of the shortage of X-ray film. Nor do we have any hesitation in drawing attention at some length here, to the benefits offered by this now adult but still far-sighted scheme, and exorting the beneficiaries to make every effort to see that they play their part, by attending punctually at the specified times.

MR. T. B. LAYTON set sail on the 28th April about midnight as a ships' surgeon. We wish him *bon voyage* and have expressed to him our hope that he will write to us from time to time and let us know how he is getting on, and what he is thinking about.

Gout

A Clinical Lecture delivered at Guy's Hospital on 25th March, 1949, by
RALPH KAUNTZE, M.D.

GENTLEMEN,—A disease, which has caused the great to limp through the pages of history, laid a peremptory grasp on Kubla Kahn, stayed Alexander, plagued Milton and Martin Luther, dogged Ronsard to his death, accounted for the irascibility of Melbourne and the petulance of the Pitts, is worthy of your consideration.

Gout is as old as civilisation. Evidence of its ravages was apparent to the ancients, who not unnaturally confused with it infective and degenerative arthritis. The converse is not infrequent to-day. They accorded descriptive names relevant to the site of the onslaught, which remain as podagra, chiragra and gonagra. Hippocrates was fully conversant with gout; he remarks on the seasonal nature of the attack, that women rarely suffer until the catamenia have stopped, that young men are free from the disease until venery is indulged, that eunuchs do not take the gout nor become bald, and that the most dangerous joint affections are seated in the thumb and great toe. Aretæus noted the prediliction for the great toe, the occasional presence of tophi and the overwhelming masculine incidence.

The term gout derives from the Latin gutta, meaning a drop and implying a pathology. For the instillation and decoction of the humors into an affected part, with the subsequent discharge of the morbid matter, was the conception of disease propounded by Galen; who somewhat acidly remarked that in his day eunuchs were afflicted with gout, from excess of sloth and rich living. The introduction of the word gout is credited to Radulfe during the XIIIth century: however Talbott quotes from an English manuscript of the Xth century, "there cam a goute in his knee, of anguische gret . . . so longue that is kneo to swal."

Murray Forbes (1793) considered that lithic acid was deposited in the joints. Wollaston, four years later, isolated urate from the tophus. In 1848 A. B. Garrod described the presence of excess of uric acid in the blood of the gouty. He ingeniously demonstrated this by the immersion of a linen thread in a glass dish containing serum, to which had been added acetic acid. Rhombic crystals of uric acid formed upon the thread in appreciable number; by comparing these deposits with known concentrations, Garrod was able to estimate the blood urate content. Garrod's work was of outstanding merit and led him to the opinion that faulty renal excretion was the ultimate cause of gout. Finally, Emil Fischer at the turn of the nineteenth century classified uric acid as a purin.

Ætiology.

Gout is a disorder of metabolism, characterised by a raised blood urate, the deposition of sodium biurate in the tissues and a tendency to recurrent attacks of acute arthritis.

By popular consent and the subscription of many physicians, high living and debauchery have been considered potent causes. This is usually correlated with the remarkably high incidence in men. But fashions change and in the halcyon days of Rome, Seneca remarked, "the nature of women is not altered but their manner of living; for while they come up to the men in every kind of licentiousness, they equal them too in their bodily disorders. Why need we then be surprised at seeing so many (of the female sex) afflicted with gout."

"Most people who have had the gout severely have deserved it," said John Hunter in forthright phrase: and Erasmus Darwin, who was addicted to cowslip wine ascribed the condition to drinking freely of "fermented liquor." Thomas Sydenham also supported this thesis, with the additional precipitant in his own case of over-work. "The gout generally attacks those aged persons who have spent most part of their lives in ease, voluptuousness, high living and too free an use of wine." He remarks the frequency in those of plethoric habit and of vigorous constitution, the lesser frequence in the slender, the usual incidence in middle age and the strong hereditary factor; finally, he stresses the onset in the early part of the year, preceded by "crudities of the stomach." Too much of the writings on the ætiology of gout carries the conviction of the compilers of the Litany and prejudice has often overridden judgment. To-day one is less sure; heredity stands out as a most potent factor. In the descendants of the frankly gouty, a raised serum urate is a finding in a considerable proportion, some of whom may reach old age or die in middle life without developing the acute phase. Talbott investigating 136 blood relatives of 27 gouty patients, found no radiological change or story suggestive of gout. In 102 the serum urate was within normal limits,

but in 34 (25 per cent.) the serum urate was higher than 6 mg. per cent. (6–10. 8). Eighty per cent. of this latter group were males, there was no retention of non-protein nitrogen and renal function was normal; their ages lay between 14 and 86. If this work be accepted, then gout is a familial disorder, perhaps sex linked, and the old phrase "gouty diathesis" is again imbued with meaning.

Do diet and liquor influence the development of the malady? Urate is the end-product of purin metabolism, just as is urea that of amino acid breakdown. The urate production is both endogenous and exogenous, that is from the breakdown of tissue or ingested material, balanced by excretion from the kidney. The equation of these should result in a constant blood uric acid. Prolonged excessive intake of purin, as with oral liver therapy, overmuch tissue destruction, as in leukæmia, or failure of renal function might each be expected to increase the blood uric acid.

In observations on patients with gout, at the Massachusetts General Hospital, Talbott found many of these sufferers belonged to the lowest income group, who could hardly by force of circumstance indulge in excess of diet or drink; and in a further group, that attacks were as frequent, or more so, on a rigid low purin diet, as when the patient was taking a normal ration with a modicum of alcohol. At present the debauchery-venery school has little other than moral support in a consideration of first causes.

Sooner or later in gout the kidney becomes affected, albuminuria, cylindruria and the inability to concentrate are apparent. In fact prognosis is dependent chiefly on renal function. But in the early years, particularly in those who have the disease in a mild form, there is no clinical evidence of renal inadequacy, or inability to concentrate urate; glomerular filtration rate, renal blood flow and capacity of the tubules to excrete diodrast all being unimpaired (Talbott). This is the antithesis of the view propounded by Garrod, namely, that persistent high blood uric acid is the outcome of diminished renal clearance. Further, urate clearance may remain normal where glomerular filtration is impaired. If these premises are accepted, then the cause of the raised serum urate must lie solely in excessive endogenous production, in the early stages of the disease. Later the situation is complicated by renal insufficiency which leads to retention of urate. Talbott states that only when glomerular filtration is reduced to 35 c.c. per minute or less (125 c.c. per minute normal inulin clearance) is retention of urate by the kidney manifest.

Given a raised level of serum urate, namely, above 5 mg. per cent.: for this is a better guide than the blood urate, what precipitates the acute attack of gout? Sydenham remarked on the occurrence of attacks towards the close of January, and Hippocrates stressed the spring and autumn. Certainly there seems some correlation between the barometric pressure and frequency of attack; the patient is usually himself well aware of this. Trauma or surgical interference are frequent precipitants. Champagne, beer and oral liver therapy have all been impugned, at times with seeming justification. Sydenham mentioned worry and mental stress. A remarkable example of this association, has been pointed out to me by Dr. Douthwaite in a man of middle age, who had suffered from four attacks at long intervals, each apparently precipitated by outstanding anxiety. Before and during the early phase of the attack the urinary output of urate is considerably reduced—the attack is thought to be associated with the deposition of urate in the tissues and the frequent polyarthritis is suggestive of a systemic rather than local upset.

Llewellyn considered an allergic basis as the trigger mechanism; this has recently been stressed by Harkavy citing tree and grass pollen.

In former days chronic lead poisoning and gout were closely associated in England and Germany; in America, however, no such affinity has been noted.

An inherent error of metabolism, together with some factor influencing renal excretion, best explain our imperfect knowledge to date.

The Attack.

No clinical description of acute gout has yet bettered that of Thomas Sydenham, which I propose to quote to you. Firstly, however, a word concerning Sydenham himself. Born in 1624, at Wynford Eagle, in Dorset, of puritan stock, he entered Oxford University at 18. After a few months he became embroiled in the Civil War. Returning to Oxford at 22, he qualified B.M. two years later, and was straightway installed as a fellow of All Souls, in place of an expelled Royalist. At 31, being out of patience with philosophic explanation, he started in practice. "Practice and speculation differing as much from each other as trifles and matters of the greatest importance: so that if my observation be right, they seldom meet in the same person." He believed that "disease is no more than a vigorous effort of nature to throw off the morbid matter."

He thought that the final cause of natural phenomena was beyond human comprehension. In consequence, his whole energies were concentrated on diagnosis and therapy, aided by full notes taken at the bedside and frequently perused. He was a supporter of Peruvian bark, fresh air in the sick-room and horse-back riding for consumptives. In 1683 Kettilby published Sydenham's treatise on "gout and dropsy." This clinical study, bearing the imprint of 34 years gout in the author, may well be considered authoritative!

"The day preceding the fit the appetite is sharp but preternatural. The patient goes to bed and sleeps quietly, till about two in the morning, when he is awakened by a pain which usually seizes the great toe, but sometimes the heel, the calf of the leg or the ankle. The pain resembles that of a dislocated bone, and is attended with a sensation, as if water just warm, were poured upon the membranes of the part affected: and these symptoms are immediately succeeded by a chilliness, shivering and a slight fever. The chilliness and shivering abate in proportion as the pain increases, which is mild in the beginning, but grows gradually more violent every hour, and comes to its height towards evening, adapting itself to the numerous bones of the tarsus and metatarsus, the ligaments whereof it affects; sometimes resembling a tension or laceration of those ligaments, sometimes the gnawing of a dog, and sometimes a weight and coarctation or contraction, of the membranes of the parts affected, which become so exquisitely painful, as not to endure the weight of the clothes, nor the shaking of the room from a person's walking briskly therein. And hence the night is not only passed in pain, but likewise with a restlessness . . . (the pain) abates not till two or three in the morning, that is till after 24 hours from the first approach of the fit. . . . And being now in a breathing sweat he falls asleep and upon waking finds the pain much abated, and the part affected to be then swelled: whereas before only a remarkable swelling of the veins thereof appeared, as is usual in all gouty fits."

In the acute attack the temperature is raised to 102° or so and there is some polymorph leucocytosis. By day the pain is lessened only, as Sydenham remarks, to return in full intensity at night. The patient is intolerably irascible. The attack may spread to involve additional joints, such as the opposite great toe, ankle, knee, fingers and wrist. With the subsidence of the acute attack the joints gradually return to clinical normality, but in section they would show deposit of sodium biurate involving the cartilaginous articular surfaces. Such deposit may, however, occur without any acute arthritis.

The second attack may arrive within a matter of days, months or years, or never make its appearance.

After several attacks the joint does not fully recover, it becomes distorted in shape and surrounded by deposits of urate in the capsule and ligaments. Bursæ are involved, as at the olecranon. Increase in these deposits marching with progressive diminution of the blood supply to the skin, at times leads to ulceration and discharge of what Sydenham aptly describes as "peccant material." These ulcerated tophi have been sources of wonder and modest profit to the sufferers, as in the barman who marked up the tally with his chalky finger. A particular and classic site of tophus formation is the cartilage of the ear: the finding of an undisputed example means gout though the patient may enjoy long life without any acute episode.

Gout is attended by precipitation of uric acid in the tubules of the kidney, and the passage of urate gravel. The kidney shows progressive damage, probably due to recurrent pyelo-nephritis and finally renal failure may close the door on life. The prognosis therefore qua life is related chiefly to renal function.

Hypertension appears to be more common among the gouty than in a similar non-gouty group, but I have no figures to support this clinical impression.

Much has been written about irregular gout. It is doubtful whether any such entity exists. The symptoms so attributed result either from hypertensive disease or renal failure. To ascribe generalised eczema, iritis, retinitis, migraine, neuritis and a host of other conditions to gout is unjustified.

Differential Diagnosis.

Recurrent attacks of arthritis in a male of middle age, of gouty family are typical. Where the acute attack involves the great toe alone and begins in the early hours the story is suggestive of gout. The appearance of the joint must be distinguished from septic infection, for incision with the almost inevitable supervention of secondary infection is to be avoided. In gout the joint is plum-coloured rather than red and the skin is shiny and does not lack lustre.

The presence of tophi is diagnostic. Where these occur in the ear they are to be distinguished from sebaceous cyst, fibroma and Woolner's tip. Woolner, as you may

remember, himself rejoiced in these small congenital projections from the helix, and being a liberal soul painted them in the portraits of his sitters. When doubt exists as to the diagnosis of tophus, a portion should be removed for chemical confirmation.

A raised serum urate in the absence of renal impairment, leukæmia, or hyperthyroidism is diagnostic of gout. Over 4 mg. per cent. in the blood or 5 mg. per cent. in the serum is sufficient. Gout may occur with lower levels, but this is unusual and casts immediate suspicion on the diagnosis. The radiological changes are late in appearance and when fully fledged are helpful but not absolutely diagnostic. Biurate deposits produce areas of translucency, there is decalcification and the joint shows narrowing and irregularity. But similar appearances result in Boeck's sarcoid, fibrocystic disease and psoriasis amongst others.

Diagnosis then depends on the family story, the site of arthritis and its course, the presence of tophi and a raised blood uric acid. With these in mind it is probable that the diagnosis should be more frequently made. Austerity may stalk through the land yet the incidence of gout probably remains little changed. It is at present an unfashionable diagnosis.

Treatment.

In the acute episode colchicum is specific. This drug, the product of the meadow saffron, was probably used by Alexander of Tralles, in the 6th century after Christ, under the name of hermodactyl. But, to be effective it must be used in adequate dosage, that is up to the production of nausea, vomiting or diarrhœa. Colchicine 0.5 mg. is given hourly (up to 6 mg.) or tincture of colchicum minims 15–20 two hourly. There is no reason to start treatment with the time hallowed purge which confuses the assessment of colchicum dosage, and such nostra as Venice treacle are of historical interest only. Fluids, a simple alkaline mixture, morphia for the pain, and a cradle to protect the foot are ancillaries. With adequate colchicum the attack should be mastered within 36 hours. In subsequent attacks the first twinge demands immediate colchicum, which the patient should have always to hand.

The intercritical period calls for rational therapy and the avoidance of fashion and fad. The diet can be full and interesting and yet avoid foods of very high purin content, examples of which are meat extracts, brains, sardines, herrings, sweetbreads, liver and what is described in general as " offal." Not that high purin diet has been conclusively shown to produce an attack, but as a sop to established custom, and to reduce the load on a renal function which may be already impaired. The maximum excretion of urate occurs with an urinary output of 1500 c.c. daily. Adequate fluid intake is therefore important and as urate is more soluble in alkaline urine, some alkaline mixture is helpful. Exercise as emphasised by Sydenham is most beneficial.

Urate appears in the glomerular filtrate and is then in part reabsorbed by the tubules: interference with reabsorption is the main means at our disposal for increasing excretion. Diodrast, mersalyl and cinchophen impede tubular absorption directly: whilst salicylic acid is excreted by the tubules, which in their haste to be rid of it, are diverted from their function of reabsorption. Diodrast would need to be given parenterally and the maintenance of high plasma levels is not at present practicable. Mersalyl must be given intramuscularly for an adequate effect; this would entail repeated injections and where renal damage is already present is contra-indicated. Cinchophen may produce untoward toxic effects upon the liver, even in therapeutic dosage, and at times when given only for three days in the week. Its effect is not I think superior to salicylate and is therefore to be avoided absolutely: in spite of the advocacy of numerous adherents. This leaves salicylate; which is best given as 10 grains q.d.s. with alkali for three days out of each week.

Most of you will be called upon to treat gout, some of you may unfortunately suffer from it. It may, therefore, be some slight consolation to reflect with Sydenham " that it (the gout) destroys more rich than poor persons and more wise men than fools: which seems to demonstrate the justice and impartiality of Providence, who abundantly supplies those that want some of the conveniences of life, with other advantages, and tempers its profusion to others with equal mixture of evil: so that . . . no man shall enjoy unmixed happiness or misery, but experience both."

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Atypical Pneumonia and Q Fever

By M. D. WARREN, M.B., B.S., Squadron Leader, R.A.F.

THE case history of what is probably the first case of Q fever to be diagnosed in England is presented below. But before recording the case history it is of interest to review some of the recent literature regarding primary atypical pneumonia, eosinophilic lung and Q fever; conditions which are clinically almost identical but ætiologically are very different.

PRIMARY ATYPICAL PNEUMONIA.

This term at the present time probably covers more than one disease. Both adjectives were criticised by Scadding recently who puts the question "What is typical pneumonia?" and then goes on to point out that if pneumococcal pneumonia is "typical pneumonia" then streptococcal and staphylococcal pneumonia must be atypical. His objection to the word "primary" is that it implies a specificity which cannot be accepted. However, as the term "primary atypical pneumonia" is in vogue it will be used throughout this article.

CLINICAL PICTURE. The onset is usually sudden with constitutional symptoms There is a general feeling of malaise with headache and muscular pains and a slight pyrexia which may reach 102–103° F., but usually is more in the region of 100° F. The patient develops a cough which may disturb his sleep and a few patients complain of a pain in the chest. This pain which may only be a tightness may on the other hand develop into a sharp pain on the same side as the lesion, but instead of being aggravated by inspiration as in a pleural pain it is more noticeable when the patient lies on that side

Physical examination is usually disappointing—sometimes no physical signs are detected. The most characteristic physical signs are a diminished air entry on the side of the lesion and post-tussive showers of medium to fine crepitations. Slight dullness and diminished movement may also be detected. The sputum is usually mucoid, occasionally blood streaked but very seldom rusty.

X-RAY CHANGES. The diagnosis will depend on the X-Ray picture. There are patchy woolly areas of consolidation seen in the lung fields occurring in any zone but more often at the bases.

SPECIAL INVESTIGATIONS. The white cell count is within normal limits but the differential count may show a relative lymphocytosis. The blood sedimentation rate is raised. In a leading article in the *British Medical Journal* in 1945 it was stated that "cold agglutinisation"—auto-agglutination of the red cells by the plasma as soon as the blood reaches room temperature—was present in 80 per cent. of cases. This has not been confirmed.

ÆTIOLOGY AND PATHOLOGY. The ætiology as stated earlier is variable. Some cases are secondary to atalectasis following an upper respiratory infection. There is evidence both negative and positive to support the theory that the infecting agent is a virus. On the negative side is the failure consistently to isolate any of the bacteria usually associated with pneumonia and on the positive side definite pneumonotropic viruses of laboratory animals have infected the laboratory workers.

The morbid pathology is a patchy, hæmorrhagic, interstitial consolidation with monocytic infiltration, acute bronchitis and bronchiolitis.

COMPLICATIONS. Pleural effusion has been reported. Rarely neurological complications develop. J. MacDonald Holmes reported two cases of peripheral neuritis, two cases of lymphocytic meningitis, and one of encephalitis as complications to primary atypical pneumonia. All his cases recovered completely.

COURSE AND TREATMENT. The condition rapidly settles down and the patient can get up after about a fortnight, and is fit to return to his work within a month. Treatment is symptomatic only.

EOSINOPHILIC LUNG.

This condition was first described by Loffler in 1932. It is not a common complaint but the mode of onset, the physical signs and X-ray appearances are very similar to atypical pneumonia and Q fever and therefore must be differentiated from these conditions.

CLINICAL PICTURE. There is usually a sudden onset of general malaise including headache, anorexia, pains in the back and a feeling of "heaviness" in the limbs. On examination there is a raised temperature which may reach 103–104° F. and lasts only for three or four days and then gradually subsides. The pulse rate is also raised and unlike atypical pneumonia is raised in proportion to the temperature. The physical signs in the chest are very few and consist merely of a few fine or medium crepitations.

X-RAY CHANGES. The X-Ray picture is very variable. There may be multiple lesions resembling tuberculous lesions or there may only be a single lesion. A feature that appears to be specific to this disease is the tendency for the shadows to appear and disappear in a very short space of time and often to actually migrate.

SPECIAL INVESTIGATIONS. The blood count together with the X-Ray appearances is diagnostic. As the chest condition begins to clear up there is a rise in the number of eosinophils, which may reach 50–60 per cent. of the total white count.

ÆTIOLOGY. This is unknown—however many theories have been advanced. The most acceptable theory is that eosinophilic lung is an allergic phenomenon. But having said that only little advance has been made. In support of an allergic phenomenon, there are the following points :—

1). The raised eosinophil count.

2). Reported association with asthma, eczema and angio-neurotic œdema.

Ascaris eggs, privet pollen, tænia saginata, amœbiasis and many other agents have been accused.

COMPLICATIONS. Pleural effusion has been reported.

COURSE. The usual course is that the disease is mild and clears up spontaneously within a few days of onset. However, more recently cases of very much longer duration and of more severe onset have been described.

Q FEVER.

Q fever was first described in 1937 by Derrick in Queensland, Australia; hence the origin of the term Q fever. It was shown by Burnet and Freeman that the causal organism was a rickettsia (now called R. burneti). It was further shown that the R. burneti were carried by cattle ticks. At the same time Montana fever was described in the United States and it was discovered that Q fever and Montana fever were the same condition.

Since this time Q fever has been described in New Zealand, Greece, Italy, Morocco, North Africa, Texas, Panama, and Switzerland. In the European countries (Greece, Italy and Switzerland) the role of ticks is not proven.

Pneumonia due to a rickettsial organism also occurs in typhus, Rocky Mountain spotted fever and South African tick fever.

CLINICAL PICTURE. The disease starts with general malaise and an intense headache—usually the headache is more severe than would be expected in view of the temperature. There is a pyrexia of up to 104–105° F. which may last for only a few days or may persist up to 14 days. Generalised aches and pains are complained of and there is a marked loss of appetite.

On examination the signs in the chest tend to be more marked and definite than in the other conditions. Crepitations and rhonchi are described. The temperature and pulse are raised. The spleen may be palpable. This is an important sign as it does not usually occur in atypical pneumonia or eosinophilic lung. (It has been reported as occurring in some series but at least one of these series is probably Q fever : see below).

X-RAY PICTURE. Is identical to atypical pneumonia.

SPECIAL INVESTIGATIONS. In the active stage the Rickettsiae burneti have been isolated from the sputum and blood by guinea pig inoculation. During convalescence diagnosis is confirmed by specific complement fixation.

ÆTIOLOGY. The disease is due to the R. burneti which, excepting Europe, have been shown to be carried by ticks. It has also been conveyed experimentally via the nasal mucosa.

COURSE. The disease usually clears up rapidly after 7–14 days' illness. Streptomycin in 30 mgm. doses has been reported as being efficacious. Chloromycetin which is reported to be successful in rickettsial infections may also be of value.

CASE HISTORY.

On 5th April, 1948, an Army Glider pilot, Sgt. P., aged 29 years, was admitted to R.A.F. General Hospital, Ely.

On admission he complained of headache and malaise. He had first noticed these symptoms on April 1st, 1948.

He stated that he had had measles as a child and since then had had three attacks of pneumonia and occasional attacks of bronchitis.

There was nothing startling in his previous history. He had joined the Army at the beginning of the war, had never served in the tropics or sub-tropics, but he had been a prisoner of war in Germany for seven months in 1945. During that time he had been quite well.

The history of the present disease was as follows: On April 1st he noticed that he had a severe frontal headache and that he felt "run down." This had developed after he had spent the previous night out on the airfield engaged in tying down the gliders. He did not attribute any particular importance to these symptoms and carried on at work. The next day he felt much the same but noticed a severe loss of appetite.

On 3rd April, he reported sick and was admitted to the Station Sick Quarters at R.A.F., Oakington. He was kept under observation for two days and was then transferred to R.A.F. General Hospital, Ely.

On admission to hospital he continued to have his severe headache, general malaise and severe anorexia. He had also by then developed a mild irritating non-productive cough.

Examination revealed a temperature of 100° F., pulse rate 94/minute and a normal respiratory rate. He appeared pale and his tongue was coated. The only physical signs in the chest were a few coarse crepitations and high pitched rhonchi at left apex and course crepitations and showers of post-tussive crepitations at the right base. The spleen was not palpable.

X-ray of the chest (report by F/Lt. G. du Bouley) showed "Right posterior basic segmental atypical pneumonia." An examination of the blood (report by S/Ldr. T. S. L. Beswick) showed 92 per cent. hæmoglobin; 4,340,000 red cells /c.mm.: 6,800 white cells with differential count polymorphs 51 per cent., lymphocytes 43 per cent., monocytes 5 per cent., basophils 1 per cent., and eosinophils 0 per cent. The blood sedimentation rate was 14 mm. fall in first hour. Cold agglutinins was negative. A sample of blood was sent to Dr. M. G. P. Stoker (1949) for Q fever complement fixation tests.

24 hours after admission the temperature had settled and the patient felt very much better. By the 15th April his X-ray was clear and the blood sedimentation rate was 3 mm. fall in first hour. He was discharged on 26th April to sick leave.

SEROLOGICAL RESULTS. As mentioned above, the serological results have already been reported by Dr. M. G. P. Stoker. On the 15th day after the onset Q fever antibodies were present in significant titre and even more so on the 33rd day when a positive result with serum dilutions of 1/80 was observed with partial fixation in a dilution of 1/160.

DISCUSSION OF CASE. This patient had spent seven months as a prisoner-of-war in Germany in 1945, and although he was never ill during that time it is conceivable that these antibodies might have been the result of a sub-clinical infection at that time. However the illness was typical of Q fever. Furthermore inquiries were made by Air Commodore J. M. Kilpatrick, Director of Hygiene, into any cases of atypical pneumonia which had occurred at R.A.F., Nethavon, the station where this patient was during the incubation period. One case, who had never left England and who had had atypical pneumonia in March, 1948, was found to have a positive complement fixation. This man had had a palpable spleen at the time of the illness. It therefore seems probable that the case history reported above was indeed a case of Q fever.

DISCUSSION. It would appear that Q fever does exist in England, and furthermore may be more commonly diagnosed as more sera from cases of "atypical pneumonia" are tested. A review of the literature in the light of recent knowledge raises the question as to whether some of the outbreaks of "atypical pneumonia" were not outbreaks of Q fever.

Thus Dr. J. W. Stevens (1948) reported 58 cases which occurred in Naples, 1946, and he remarks that Robbins et al (1946) demonstrated that "Mediterranean Q fever occurred as a sporadic disease in Southern Italy in the vicinity of Caserta and Naples." Stevens admits that his cases may well have been cases of Q fever. Unfortunately no serological examination was carried out.

The points of interest in his cases were severe headache, only a slight dry cough, definite presence of physical signs in the chest (rhonchi and crepitations), enlarged spleen and occasionally an enlarged liver and severe loss of appetite. Retrospectively these symptoms and signs are more suggestive of Q fever.

ACKNOWLEDGEMENT. It must be emphasised that the diagnosis of the case reported above was entirely due to the examination of serum by Dr. M. G. P. Stoker. The case was initially diagnosed as "atypical pneumonia" and because of this diagnosis serum was sent for a complement fixation test.

My thanks are due to Air Marshal P. C. Livingston, Director General of R.A.F. Medical Services, to Group Captain Rumball, Consultant in Medicine, for permission to publish the case and also to Dr. M. P. G. Stoker for permission to quote his laboratory findings and to Sgt. P. for his willing co-operation.

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Students' Health Service

BETWEEN May 20th and May 27th, a mass miniature radiography unit is being sent to Guy's in order to X-ray the students and administrative and technical staff of the Schools. The nurses, together with students in the Physiotherapy and Radiography Schools will also be examined.

In order that the unit may be used to best advantage and the large number of skiagrams taken with the greatest economy of time, it is very important that the organisation should proceed smoothly. Every medical and dental student will receive before May 14th a letter giving him the time he should attend for this X-ray examination. If a student does not receive a letter by that date he should apply to the Secretary to the Students' Health Service for an appointment. The appointments for students doing preclinical studies have been arranged in "years," and arrangements have been kindly made by the Dean and the Heads of Departments concerned to make it possible for everyone to attend at the appointed time. Appointments for students in their clinical years have been made on days that as far as possible are convenient for them, but it will be appreciated that there must be many cases where the appointment conflicts with some other duty. As the radiographic examination will only take a few minutes, it is hoped that everyone will keep his appointment even though this may mean some inconvenience in a few cases. Working out a timetable has been a complicated matter, and I regret that it is impossible to change the times of appointments.

The Dean has agreed that the examination, on this occasion, should take precedence over other School activities. The School Council has decided that attendance for routine medical and radiological examination is a condition of studentship.

The circular is also being sent to House Officers but no timed appointment has been made. Each Resident should, however, telephone the Secretary to the Students' Health Service who will then make an appointment which is mutually convenient.

I hope that we shall be able, by this method, to X-ray the whole of the School. Such examinations are of enormous importance in discovering cases of early tuberculosis which still remains a frequent misfortune among medical and dental students and House Officers.

If the miniature film is normal, the student will hear nothing further about it; if its appearances suggest abnormality, or if it is inconclusive, the student will be asked to attend for a full sized film to be taken. It must be realised, however, that to be asked to attend in this way does not necessarily mean that the student has any disease of the lungs; it may mean simply that the miniature film gives insufficient detail for a final conclusion to be drawn.

W. N. MANN.

Recent Advances in Dietetics

By Sir HARLEY WIMPOLE, M.A. (Andaman), D.Sc. (Perim), M.D. (Tristan d'Acunha), Hon. LL.D. (Spitzbergen), D.C.L. (Erewhon), etc., etc.

AT a time when the cry of the Government is for more and more production—more and more exports—more and more work—it is pertinent to consider carefully every factor which will contribute to the contraction of The Great Hiatus, politically known as "The Gap."

To that end, if the cliché may be pardoned, it will not be inappropriate to recall my article on "Starvatio Nocturnus," which was published in the *Gazette* in 1936. A review of the literature of that period appeared to demonstrate that this disease chiefly affected persons in a particular social stratum, who had to work for their living. Although others may have suffered from the disease, if in fact it was ever a pathological entity, it was no handicap. The class commonly affected were those often referred to as "Daily Breaders." Unmarried females with dependants, manageresses, married men with wives and families to support, engaged couples, foremen, commercial travellers, secretaries, vacuum-cleaner salesmen and works managers. It was an occupational disease in that it affected people of all occupations; a "class" disease, because its incidence was highest in the wage earning classes. It was never seen in the wealthy, and no millionaire has ever been stricken by it, although in some respects there was a clinical resemblance to what has been called "the morning after." For further signs and analytical tables readers are referred to page 168 of the *Gazette* for 1936.

Medicine is a progressive science, and since those days we have passed through the sulphonamide era—if indeed we have yet passed through it; for there are still elderly practitioners whose belief in this archaic method of treatment remains unshaken—and this despite the advantages which have been claimed for mushroom remedies such as Penicillin and Streptomycin. In speaking thus plainly I am not unmindful of the meritorious work of my old friend Sir Alec Fleming and a man named Florey—not to mention a few others.

The point I wish to make is that Starvatis Nocturnas, as a disease likely to interfere with production, has passed, with Chlorosis ("*La maladie verte*") and Ptomaine Poisoning, into the limbo of forgotten things; at any rate if the columns of the daily press are any guide.

More and more, the importance of Sleep, "tired Naturis sweet restorer," has come to be recognised. Not necessarily long sleep but deep sleep. Is it not strange that in far-off days it was claimed that Starvatis Nocturnus, which never affected night-watchmen, exercised its virulently noxious influence upon mind and body during the hours devoted to sleep?

Recent researches in the realm of dietetics have elicited the astounding and revolutionary fact that *only deep sleep has the power to put back into your body the energy and vitality you use up during the day*. Not the metabolism of food, that ana-katabolic biochemical process in which substances of high potential energy are reduced to a lower potential. These would appear to play little if any part in maintaining a state of physiological efficiency. You can forget all about 1st and 2nd Class Proteins, Fats and Carbohydrates, once the bugbear of the dietician. Sleep, deep sleep and *only deep sleep* is all that is required.

But the wheel has turned full-circle. The identical remedy which was claimed as specific treatment for Starvatio Nocturnus has been proclaimed as the one and only therapeutic agent which will produce sleep of the right kind. I refer, of course, to Hordeised Succus Vaccæ, which is obtainable commercially in dehydrated powder form.

Researches with this substance were carried out in my own laboratory. Attempts were made to anæsthetise ordinary laboratory animals by inhalation and dusting externally. Aqueous suspensions were administered intradermally, hypodermically, intramuscularly, intravenously, intraperitoneally, and intrathecally, all with negative result. Greatly interested in my work, a number of my students heroically offered themselves for experiment, and to each was administered *per os*, aqueous suspensions of the dehydrated hordeised succus vaccæ in varying quantities to a maximum of 500 c.c., after first undergoing a very strenuous period of dinner-plate filling, up-washing, queuing, floor-scrubbing, and sock-mending.

The result succeeded beyond all our expectations. In exactly 4.7693 seconds they all sank into a sleep so deep that they could not be awakened until the expiration of 24 hours, 15 minutes, 58.9999 seconds, when they wakened simultaneously.

I am sorry to have to record that when released to return to their respective domiciles there was an unfortunate accident. As they crowded round the 'bus to board it, they unfortunately pushed it over. Fortunately nobody was hurt and they quickly lifted it back on to its wheels.

Further experiments are in train to test its efficacy as a general anæsthetic in surgical cases and as an analgesic in labour.

There seems to be some promise that this remarkable preparation may enable the Government to abolish food rationing—and food.

Correspondence

"What is the Meaning of This?"

SIR,—Could it not be, to use a trans-Atlantic colloquialism, that we have been "taken for a ride"? Guy's has a noble tradition—we think of our patients as human beings and not as walking diseases. We look before we leap and think before we cut—and sometimes do not cut at all!

To-day, whilst studying the painting which adorns the new common-room, a sinister thought entered my head. This painting could be interpreted as a joke at our expense! Looking from left to right—I have sat in dentist's waiting-rooms and read *The Tatler*—first we see the patient entering the hospital past the statue of Thomas Guy and next we glimpse the ward wherein he is installed. The doctors and students are then shown gaining knowledge in Wills' library so that they shall know their treatment of the case. But, alas, they spend so much time upon the rugger field, as depicted in the next section, that by the time the patient is shown "on the table," disaster overtakes him and he walks off to the right—a fleshless, grinning skeleton. In retrospect, the doctors, re-examining his X-ray, say: "Of course—now we see—that wasn't a foreign body after all—it must have been his heart!" The cat, duly becollared lest it be "dealt with as a stray," wanders in the park, where nature, urged by green fingers, holds her sway and Thomas Guy looks on. Does his expression, in this picture, look approving? Did he hope for this?

Yours, etc.,

J. G. ARMSTRONG.

Guy's Hospital, S.E.1.

(*A copy of the picture to which our correspondent refers was published in the* GAZETTE *of 18th December*, 1948.—ED.).

"Founder's Day"

SIR,—Many will have read the announcement in the last issue of the *Gazette* that after some two centuries Thomas Guy, our founder, is to be commemorated by a Founder's Day Service in the Chapel. It would be interesting to know why May 6th was chosen. The date of Guy's birth is unknown, and he died on December 27th, 1724. The first sixty patients were admitted to the Hospital on January 6th, 1725, and this surely would seem to be the date of the founding of the Hospital. Perhaps like the King's birthday an arbitrary day has been chosen or perhaps it is because that on May 6th, 1724, the minutes of St. Thomas's Hospital happen to record thanks to Guy "for his unparalleled bounty in gifts to this hospital and in erecting at his own charge another hospital for incurables."

IAN SCOTT.

Guy's Hospital, S.E.1.

Visiting Surgeon

OUR surgical visitor from the Johns Hopkins Hospital for this year is Dr. Mark Ravitch, a whole-time surgeon on the staff of that Hospital, where he works in Dr. Blalock's department. His particular interests are the colon and rectum, and he is elaborating the anal ileostomy operation for congenital polyposis coli and ulcerative colitis. We look forward with eager anticipation to his arrival in June, and to his clinical lectures, operating lists, rounds, demonstrations and Out-patient sessions, and are reminded once again of the generosity of the Worshipful Company of Clothworkers, who made these exchange visits possible.

Poem

AUTUMN IN BEDFORDSHIRE.

The long far curve of stubble on the clay;
A languid yellow sun falls through the day
On farm and byre.
Some purple cloudy woods beyond them stay;
The golden landscape stands in still array
In Bedfordshire.

The crawling shadows push across the earth.
The misty evening darkness comes to birth
On tree and spire.
The servant and his master homeward come:
Homeward the laggard crow when day is done
In Bedfordshire.

J.C.D.

Reviews

The Early Recognition of Disease. Edited by Sir HENEAGE OGILVIE and WILLIAM A. R. THOMSON. Eyre and Spottiswoode. *Price* 10*s.* 6*d.*

THIS is another "Practitioner Handbook" composed largely of articles that have appeared in that journal by specialist contributors and designed to re-orientate ideas on early diagnosis in accordance with the newer knowledge of disease processes. Unfortunately not all the chapters are of a uniformly high standard. Moreover, to most Guy's men the approach followed will be no novel experience. One lesson is obvious from this book—the early recognition of disease calls for the employment of numerous ancillary methods of investigation in addition to the unaided "five senses" on which the doctor has depended for so long.

As reminders to a busy practitioner these articles, when first printed, must have had a timely significance. The justification for making them up in book form is doubtful. The final year student might well read them with interest but without obligation.

G.

Textbook of Medicine. Edited by Sir JOHN CONYBEARE. 9th Edn. Livingstone. *Price* 30*s.*

"CONYBEARE" needs no recommendation. Established not only at Guy's but throughout the medical schools of the country as a text-book for undergraduates that is at once comprehensive, concise and readable, this work also commands a wide circle of readers among qualified medical men.

The new edition, the ninth in twenty years, has been thoroughly revised. The contributors remain much as before. The format, however, is changed—to Royal Medium 8vo. which the publishers claim "is much more easily handled." We are doubtful of this.

At all events, with the price unaltered at 30s., this textbook is an extremely good investment.

G.

Elementary Anatomy and Physiology. By J. WHILLIS. 3rd Edn. Churchill. *Price* 16*s.*

THIS textbook is a most valuable introduction to the study of Anatomy and Physiology. The text has been carefully confined to essentials, and the correlation of structure and function gives added interest, while at the same time providing a logical approach to the study of these subjects. Those requiring an elementary knowledge of Anatomy and Physiology during their training will find that this book meets their requirements.

The third edition has been completely revised and although the section on muscle form and movement has been extended and the subject of skeletal dynamics introduced, the book has not been appreciably lengthened.

The illustrations are clear and the book is well produced.

Human Histology: A Guide for Medical Students. By E. R. A. COOPER. 2nd Edn. Lewis. *Price* 27*s.* 6*d.*

THIS textbook gives a comprehensive survey of normal Human histology and the subject is presented in relation to anatomy, physiology and pathology. Practical work is detailed at the end of each chapter so that the book may in addition be used as a laboratory guide.

The illustrations are numerous and excellently produced, but in general are rather too small and in some cases of insufficient magnification to give an adequate picture of the structure depicted.

Proceedings of the Annual Meeting of the B.M.A., 1948. Butterworth. *Price* 35*s.*

THIS is a finely produced volume, well indexed, of some four hundred pages. As is only natural, there is something to interest everyone, but only a small portion of the whole to interest any one. Much of what is written was clearly said to invite controversy at the time, so undergraduates beware.

H.A.R.

Cardiology. By WILLIAM EVANS. Butterworth. *Price* 35*s*.

THIS book is a most valuable addition to the current literature on cardiology, as it is written entirely from the practical standpoint. Indeed one of its greatest uses is the clear and diagramatic manner in which the relative efficacy of the various diuretics is illustrated, and the fact that every statement, concerning treatment at any rate, has been born out by practical experience. It is a pity, however, that in a book of this size and comprehension the surgery of the heart has not been more fully gone into, as references to this well established branch of cardiology are fleeting. This lapse apart, the book can be strongly recommended and its clear format and many diagrams makes for easy reading.

K.E.

Modern Practice in Psychological Medicine. Edited by J. R. REES. Butterworth. *Price* 50*s*.

IN this book Dr. Rees, with twenty-eight distinguished collaborators, including Dr. Munro of Guy's, has provided a first-class guide to present-day theory and practice in psychiatry. Each member of the team is especially equipped by inclination and experience to represent his own section of the field; thus, Dr. Slater writes on inheritance in psychiatry, Dr. Munro on the affective disorders, and Dr. T. F. Main on industrial stress and psychiatric illness. There are sections on the medico-legal aspects of psychiatric work in the three divisions of Great Britain, and in America, and a chapter on psychosomatic medicine by its chief protagonist in this country, Dr. Eric Wittkower. In short, the field is so well covered that this symposium may well be regarded as the practitioner's best modern textbook of psychiatry.

D.O'N.

Penicillin and other Antibiotics. By G. W. S. ANDREWS and T. MILLER. Todd Publishing Group. *Price* 7*s*. 6*d*.

THE evolution of present knowledge of antibiotics particularly penicillin, is excellently summarised, and the approach to further investigation clearly indicated.

Clinicians, students, and laboratory workers alike will find here a sound basis on which to found their ideas of the scope and limitations of this important group of substances.

The clear and interesting manner in which the chapters are presented makes the book easy and pleasant to read.

B.J.S.

Skin Diseases in General Practice. By F. RAY BETTLEY. Eyre & Spottiswoode. *Price* 21*s*.

THE general practitioner may hope to become an adequate dermatologist if he practises long enough. This book should help him: it is practical, well arranged and tells the reader what he wants to know.

The Author deals only with common diseases, but discusses these very fully, beginning each chapter with an excellent introduction and then going into the pathology, diagnosis and treatment. It is definitely a book worth reading twice and then keeping on the shelf for reference.

C.H.R.

Handbook of Midwifery. By MARGARET PUXON. Sylviro Publications. *Price* 25*s*.

THE facts in this handbook are accurate and the methods of treatment, with one or two exceptions, are in accordance with present day opinion. The author has set herself the very difficult task to produce a work which is condensed and yet is not a series of notes. The postgraduate may find this book interesting, and useful, but it is likely to prove more difficult to assimilate than the standard textbooks and thus, for the student, it is not recommended.

G.T.H.

Clinical Endocrinology. By LAWRENCE MARTIN and MARTIN HYNES. Churchill. *Price* 15*s*.

FOR a textbook of this size, the amount of material included is surprisingly large, and for the wider reader the list of references is extensive. The authors have succeeded admirably in giving a concise but balanced outline of the elements of endocrinology and have avoided the excessive terminology which is only too common in books of this type. The text is accurate and well set out, and such controversial subjects as thiuracil are discussed in fair perspective. This book should be of value to both Practitioners and Students alike.

K.E.

Also received—

Aids to Biochemistry. By E. A. COOPER and S. D. NICHOLAS. 4th Edn. Bailliére, Tindall & Cox. *Price* 5*s*.

Aids to Physical Chemistry. By R. G. AUSTIN. 2nd Edn. Bailliére, Tindall & Cox. *Price* 7*s*. 6*d*.

Aids to Psychology. By JOHN H. EWEN. 3rd Edn. Bailliére, Tindall & Cox. *Price* 5*s*.

Hints on Prescribing. By J. B. PRIMMER. Heinemann. *Price* 3*s*. 6*d*.

First Steps in Childhood. By G. M. KERR. Clerke & Cockeran. *Price* 3*s*. 6*d*.

Aids to Surgical Nursing. By KATHERINE F. ARMSTRONG. 4th Edn. Bailliére, Tindall & Cox. *Price* 6*s*.

Aids to Tray and Trolley Setting. By M. HOUGHTON. 4th Edn. Bailliére, Tindall & Cox. *Price* 5*s*.

Guy's Diary

MAY

ACADEMIC

Exhibition. Surgical Dept. "Swellings of the Neck."

9th. M.R.C.P. Course Commences.
1.00. Mr. Atkins. Clinical Lecture. "Endocrines and Carcinoma of the Breast."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

10th. 12.00. Dr. M. J. McArdle. Neurological Demonstration. Preclinical Classroom.

11th. 4.45. Guy's Science Club. Dr. D. F. O'Neill. "Physical Methods in Psychiatry." Staff Common Room. (Tea 4.30).

12th. 12.00. Mr. R. J. Cann. Dental Clinical Lecture. "Where the Dental Surgeon and the Rhinologist meet." Dental Theatre.
1.00. Mr. Wass. Clinical Lecture. "Malignant Diseases of the Mouth."
4.30. X-ray Meeting. Gordon Museum.

13th. 1.00. Dr. Hardwick. Clinical Lecture.
2.15. Medical Dept. Combined Surgical and Medical Round. Preclinical Classroom.

14th. 10.00. Mr. E. G. Muir (King's College Hospital). Surgical Departmental Round. Clinical Theatre.

16th. 1.00. Dr. Wayte. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

17th. 12.00. Mr. K. E. Pringle. Dental Clinical Lecture. "Some Treated Orthodontic Cases." Dental Theatre.
1.00. Mr. Blackburn. Clinical Lecture. "Acute Cholecystits."

19th. 1.00. Mr. Willmore. Clinical Lecture. "Speech, Pathology and Therapeutics."
4.30. X-ray Meeting. Gordon Museum.

20th. 1.00. Professor A. Bradford Hill, Ph.D., D.Sc. (Professor of Medical Statistics, London School of Hygiene and Tropical Medicine). Clinical Lecture. "Statistics in Medicine."

20th. 2.15. Medical Dept. Combined Round. Preclinical Classroom.

23rd. 1.00. Professor M. A. Rushton. Clinical Lecture. "Some Mandibular Deformities."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

Sport

CRICKET

1st XI FIXTURES, 1949.

2.30 p.m. start unless otherwise stated.

May			
4th	Wanderers	H.O.P.	11.30 a.m.
7th	Honor Oak	H.O.P.	
8th	Ashstead	Away	2.00 p.m.
12th	Stoics	H.O.P.	11.30 a.m.
14th	Wadham Coll., Oxon.	Away	11.30 a.m.
21st	Private Banks ..	H.O.P.	
22nd	Old Blues	H.O.P.	
28th	Hampstead	H.O.P.	
29th	Thespids	H.O.P.	
June			
4th	Bognor Regis ..	H.O.P.	
5th	Finchley	Away	
6th	Crofton Park ..	H.O.P.	11.30 a.m.
8th	Holloway Sanatorium	Away	11.30 a.m.
11th	Kenley	H.O.P.	
18th	Metropolitan Police..	H.O.P.	
19th	Horlicks	H.O.P.	11.30 a.m.
26th	Bognor Regis ..	Away	11.30 a.m.
July			
2nd	Ealing Dean.. ..	Away	
3rd	Streatham	H.O.P.	
6th	Addiscombe	Away	11.30 a.m.
9th	Three Counties Hosp.	Away	12.0 noon.
10th	Nomads	H.O.P.	2.00 p.m.
16th	Private Banks ..	Away	
17th	Buccaneers	H.O.P.	11.30 a.m.
23rd	Old Whitgiftians ..	Away	11.30 a.m.
24th	Sutton Tramps ..	H.O.P.	2.00 p.m.
30th	Finchley	H.O.P.	
31st	Mr. J. Tanour's XI..	H.O.P.	11.30 a.m.
Aug. 6th, 13th	South Devon Tour.		
27th	Metropolitan Police..	Away	
Sept.			
3rd	Kenley	Away	

SQUASH

At a meeting of the Guy's Hospital S.R.C., held on March 24th, the following resolutions were passed :—(1) The services of a Professional Coach to be obtained, if possible. (2) A singles competition to be held in the Christmas Term. (3) "A" Team fixtures to be resumed during the 1949–50 season.

The following officers were elected for the 1949-50 season : President—Dr. Charles Baker ; Vice-Presidents—Dr. T. M. L. Price, Dr. E. B. Reeve ; Captain—D. R. Pugh ; Hon. Secretary—P. L. Pickett.

SAILING CLUB

THE OGILVIE CUP.

Racing for the Ogilvie Cup, last competed for in 1934, will be resumed this season. The race will take place in U.H.S.C. dinghies at Burnham-on-Crouch on Friday, July 22nd. Entries must reach the Secretary before July 12th.

INTER-HOSPITAL RACING.

The first race of the season on April 16th was won by St. Thomas' with London 2nd, Royal Free 3rd, Guy's 4th, St. Mary's 5th—the Middlesex boat did not finish.

On April 23rd, St. Thomas's again won, Guy's 2nd, U.C.H. 3rd, Royal Dental Hospital 4th.

MUSIC CLUB

The Music Club are giving a Choral and Orchestral Concert in the Physiology Theatre, Guy's Hospital, on Wednesday, May 18th, at 8 p.m., when works by Handel, Mozart and Fauré will be performed. All members of the Hospital Staff and Schools are cordially invited. No tickets are required, but seats can be reserved.

ARTHUR G. BLYTH,
Hon. Sec.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

MEDICAL SCHOOL

Applications are invited for the appointment of **Junior Assistant to the Director of the Department of Medicine.** Duties to commence as soon as possible. Applicants should hold a higher qualification. Appointment will be until 30th September, 1949, in the first instance. Salary £750, plus superannuation and family allowance.

Forms of application obtainable from the Medical School Office and should be lodged with the Dean not later than 26th May, 1949.

DENTAL SCHOOL

Applications are invited for the following posts commencing 1st October, 1949 :—

Dental Surgery
3 Half-time Assistants to the Director of the Conservation Room.
4 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.
1 Demonstrator for 1 session per week.
Administrative Dental Officer (Half-time).

Extractions and Minor Oral Surgery
2 Half-time Assistants.

Dental Mechanics and Prosthetics
2 Half-time Assistants to the Director of Dental Prosthetics.
2 Demonstrators for 3 sessions each per week.
2 Demonstrators for 2 sessions each per week.

Dental Department for Children
1 Half-time Registrar (6 sessions per week).
2 Part-time Registrars for 3 sessions each per week.

Preventive Dentistry
1 Half-time Director.
2 Half-time Assistants.

Clinical Pathology (Dental)
1 Assistant Clinical Pathologist (Dental).

Special Anatomy and Histology
1 Half-time Demonstrator.

Forms of application may be obtained from the Medical School Office and should be returned on or before Friday, 20th May, 1949.

INNOMINATE CLUB

The Annual Dinner of the Innominate Club will be held at the Trocadero Restaurant at 7.0 for 7.30 p.m. on Friday, June 10th, 1949. Dress optional. Tickets one guinea. Will those who wish to attend please communicate with the Secretary, G. T. Hankey, Esq., 89, Harley Street, W.1. In the afternoon of June 10th, Innominate members will be welcomed to the Ward Rounds, Operations and Demonstrations given by the Senior Staff of Guy's Hospital. Will those who wish to attend please advise Mr. N. L. Eckhoff beforehand.

PASS LIST

CONJOINT BOARD

April, 1949.

Pathology.

D. Barker	L. W. Mackey
G. Canty	M. Mason
J. F. le Clus	Q. F. Nethling
J. D. Crowlesmith	G. F. M. Pierce
D. W. A. Drew	J. K. Price
R. H. P. Fitzpatrick	E. H. O. Smith
J. Frederick	O. L. Thomas

Medicine.

J. G. Brice	*A. Goldstein
*P. Buri	*J. A. B. Jones
*P. R. Chalk	*A. H. Phillips
*J. M. Frisch	*A. E. Richardson

Surgery.

R. G. Beard	*J. A. B. Jones
*E. Beswick	L. C. Kreeger
*R. M. Brown	J. C. Lindsay
*P. Buri	*P. G. W. A. Lommerse
*B. G. B. Christie	*A. H. Phillips
*F. G. Ellis	*B. Plant
*J. R. Greaves	*H. H. Richards
B. Hartley	*A. E. Richardson
K. M. Herd	*R. G. M. Stobie

Midwifery.

H. M. Baird	R. Goulding
B. H. Bass	T. S. Hart
R. Baxter	J. W. Hughes
R. G. Beard	I. Kent
D. G. Bluett	I. Rocker
A. G. Blyth	M. J. R. Mackrill
A. E. R. Buckle	R. C. Nauth-Misir
J. C. Camac	T. M. Owen
*D. G. Chalmers	A. M. Reader
P. J. Cook	*H. H. Richards
D. F. C. Deacon	K. F. Robinson
R. H. P. Fitzpatrick	P. S. B. Russell
J. Foley	W. H. Watson
N. S. Galbraith	R. H. R. White

*Have completed the Examination.

UNIVERSITY OF LONDON

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

March, 1949.

R. K. Allday	E. A. Murray
P. K. M. Barrett	J. M. Newton
F. J. Bateman	C. H. Opie
E. W. G. Birch	P. Packer
L. H. Brearley	M. J. Pentney
C. P. B. Brook	H. S. Reeve
R. W. Brotherwood	D. S. Robinson
E. E. Chapham	J. R. Robinson
H. P. Duke	A. Ross
J. Eastwood	F. C. Shelley
P. S. Elias	G. B. Skinner
F. C. Emberton	A. J. Smith
E. Fincham	R. C. Smith
E. R. Herz	E. C. Spencer
J. C. M. Heylen	A. G. Spooner
B. G. Jackson	C. H. W. Warne
P. F. P. Lansdown	J. D. Waye
D. A. F. McGill	D. C. Wilkins
I. Macmillan	J. Woodford
B. L. Mallett	P. A. Zorab

The following Candidate has qualified for entry to Ph.D. :

B. W. L. Brooksbank

UNIVERSITY OF OXFORD

B.M., B.Ch.

Pharmacology and Principles of Therapeutics.

W. T. Barrett	J. A. Smith
D. J. Muller	R. A. J. Williams

Forensic Medicine and Public Health.

J. G. Armstrong	W. A. Openshaw

Special and Clinical Pathology.

J. G. Armstrong	A. C. M. Mann

General Pathology and Bacteriology.

E. J. Elkington	R. A. J. Williams
J. E. K. Moore	J. H. Wilson
D. J. Muller	

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Diploma.

T. H. Eustace	J. E. Gilbert

ROYAL COLLEGE OF PHYSICIANS OF LONDON

M.R.C.P.

I. S. Eve C. L. Joiner P. A. J. Smith

WEST LONDON HOSPITAL

Mr. R. C. Brock will deliver the second Alex. Simpson Smith lecture at 11, Chandos Street, London, W.1, on Wednesday, June 15th, at 8.30 p.m on the Surgical Treatment of Congenital Pulmonary Stenosis.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Professor Robert Bradlaw has been elected fellow of the College.

PAPERS BY GUY'S MEN

Atkins, H. J. B. Effect of Endocrines on Fibroadenosis. *Brit. Med. J.*, 1949, i, 750.

Bachelor, J. S. Ætiology and treatment of Torticollis. *Brit. Encycl. Med. Pract., Interim Suppl.*, 79, 1947 (April), p. 9.

Chapman, Harold. Practical Observations. *Dental Rec.*, 1949, **69**, 64.

Clarence, T. S. Three Tips. *Brit. Dent. J.*, 1949, **86**, 182.

Erskine, David. Epidermophytosis. *Med. Pr.*, 1949, **221**, 357.

Forman, L. An unusual Nævoid Condition of the Skin (Presented by E. J. Moynahan). *Proc. Roy. Soc. Med.*, 1949, **42**, 137.

Hallam, John. The Importance of the control of Blood during Dental Extractions. *Brit. Dent. J.*, 1949, **86**, 205.

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Harding, H. E., and Another. Changes in the Lungs produced by Natural Graphite. 1949, **6**, 91.

Hore, W. G. R., and Another. A case of Accessory Sinus Tuberculosis. *J. Laryngol-Otol.*, 1949, **63**, 235.

Matthews, E., and Another. An investigation into the Organic Components of the Human Tooth. A Study of Sound and Carious Dentine. *Brit. Dent. J.*, 1949, **86**, 167.

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Moss, Louis. The treatment of Chronic Rheumatism. *Med. World*, 1949, **70**, 244.

Nancekievill, L. Acute Idiopathic Pulmonary Hœmosiderosis. *Brit. Med. J.*, 1949, i, 431.

Nicholson, D. P. Pulmonary Collapse in Pertussis. *Arch. Dis. Childh.*, 1949, **24**, 29.

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Osman, A. A. Anuria. *Brit. Encycl. Med. Pract., Interim Suppl.*, 79, 1947 (April, 1949), p. 13.

Partridge, M. Pre-Frontal Leucotomy. *Practitioner*, 1949, **162**, 224.

Rees, R. J. W. Primary Multiple-Pressure Vaccination of Infants. Comparison with Scarification. *Lancet*4 198, ii, 943.

——, Jackson, F. L., and Others. Specific Laboratory Tests in Streptomycin Therapy of Tuberculosis. *Lancet*, 1948, ii, 862.

Rumble, J. F. S. Twenty-five dental cases treated with absorbable Alginate Wool. *Brit. Dent. J.*, 1949, **86**, 203.

Rushton, M. A. The Fibre-structure at the Gingival Attachment of Deciduous Teeth. *Brit. Dent. J.*, 1949, **86**, 105.

Sears, W. G. Treatment of Barbiturate Poisoning. *Practitioner*, 1949, **162**, 247.

Scott, L. G. (for Evans, P. R.). Hepatic Glycogen Disease. *Proc. Roy. Soc. Med.*, 1949, **42**, 84.

Siggers, N. An unusual Dental Case. *J. Dent. Assn., South Africa*, 1949, **4**, 68.

Simpson, Keith. Deaths from Vagal Inhibition. *Lancet*, 1949, i, 558.

Simpson, Keith. The Pathology of Blunt Head Injury. *Annals Roy. Coll. Surg., Eng.*, 1949, **4**, 232.

Smith, P. A. J. Dermatitis Nodularis Necrotica. *Proc. Roy. Soc. Med.*, 1949, **42**, 143.

Stafford-Clark, D. Morale and flying experience. *J. Ment. Sc.*, 1949 (Jan.), p.10.

Stamm, T. T. Brachial Neuritis. *Med. Pr.*, 1949, **221**, 243.

Swift, P. N., and Another. Pulmonary Lesions in Rheumatoid Arthritis. *Brit. Med. J.*, 1949, i, 434.

Symonds, Sir Charles. Reorientations in Neurology. *Lancet*, 1949, i, 677.

Symonds, Sir Charles. Facial Pain. *Annals Roy. Coll. Surg. Eng.*, 1949, **4**, 206.

CHANGE OF ADDRESS

J. Sephton Cooper, M.B., B.Ch., Hollenden, Foxholes Hill, Exmouth, S. Devon. (Tel.: 2118.)

H. S. M. Crabb, B.D.S., 2, Ashburton Road, Addiscombe, Croydon. (Tel.: Addiscombe 6150.)

David Ebsworth, M.R.C.S., L.R.C.P., D.A., 55, Hans Mansions, S.W.1. (Tel.: Ken. 4491.)

A. B. Kettle, M.D., 19a, Ellenborough Park North, Weston-super-Mare. (Tel.: 6318.)

C. H. Laver, F.R.C.S., B.M., B.Ch., Firle, The Way, Reigate, Surrey. (Tel.: Rei 5100.)

BIRTHS

MAYNE.—On April 19th, 1949, to Frances (née Watson), wife of Dr. A. H. Mayne, Three Corner Park, Calstock, Cornwall—a brother for Peter.

THORNE.—On February 28th, 1949, at 18, Holly Lodge Gardens, Highgate, N.6, to Dorothy (née Poole), wife of Martin G. Thorne—a daughter (Elizabeth).

WHEELER.—On 7th April, 1949, to Daphne Laurie (née Fullbrook), wife of Stanley John Wheeler, Southcourt House, Aylesbury, Bucks.—a son.

WILLCOX.—On 8th April, 1949, to Julia (née Fleming), wife of G. F. Willcox—a daughter (Charlotte Loraine).

MARRIAGE

PLATT—MORRISON.—On Friday, April 29th, 1949, in London, A. Manfred Platt, L.D.S., R.C.S., of Cape Town, to Audree Morrison, of Johannesburg.

DEATH

THOMAS.—On March 22nd, 1949, Frank Griffith Thomas, M.B., B.Ch., of Canford Cliff, Bournemouth, aged 76 years.

EDS. {H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

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PASSIM

FEW of our readers will not already know that Guy's is now equipped with television, not merely passively as receivers but most actively as performers. Every credit is due to the Department of Surgery and, in particular, to the Director for the part played in this new venture. There is a tendency to-day—perhaps it is a symptom of the times—to be ultra-sceptical or even derisive of new ideas. Yet never before in history could we less afford to stifle enterprise. Not all innovations survive by any means, but those which do are acclaimed in retrospect as signal achievements. Whether television in surgery will fall into this class only time will tell.

An account of the installation is given elsewhere in this *Gazette*. Those that have already appeared in certain sections of the daily press were probably more entertaining, if less factual. Reporters and cameramen were received in the department a week or so ago. Their interest was, as usual, avid. Their reactions, however, especially after being given an opportunity to see the operation actually in progress without the intermediation of the television, were not so heroic. Some of the otherwise phlegmatic members of the party turned a perceptible shade paler and sought anxiously for the tea provided.

After the first round of applause comes the interval for reconsideration. What exactly will be achieved by this new medium? First it must be realised that those most likely to benefit are the surgeons and surgical trainees. The undergraduate medical student scarcely requires a familiarity with operative procedures. Secondly, there is no adequate substitute, and probably never will be, for actual participation. Nevertheless, those who find it necessary to watch operations may well find it easier to do so before a television screen than jostling with others in the turmoil of the theatre. An extra burden, moreover, will be placed upon the surgeon who attempts to demonstrate before the camera and the microphone. (No suggestion has yet been made that auditions and photogenic tests should be instituted!). At the special display for the press the Director acquitted himself with distinction but, admitting to the extra strain of that occasion, he certainly showed signs of some exhaustion afterwards. Finally, the reproduction at the moment is far from perfect. Definition is still lacking and depth is lost. Technical adjustments will no doubt overcome these defects before long.

This further aid to learning in the shape of television, which has found Guy's in the vanguard as well as in the news, draws attention once again to the ultimate objective. Demonstration and the written word no longer suffice. All manner of ancillary devices for instruction have been introduced. Auditory approach by formal lecture has long been accepted; visual aids are of more recent creation. In the field of medical illustration Guy's has again afforded notable example. Though an article on this subject in a recent number of *The Lancet* drew forth criticism from Mr. T. B. Layton, the advantage of this pictorial work is widely praised. Technical films, too, are almost a vogue. The intention is for reels on specific subjects to be made by the Photographic Department. (In this connection, readers may be interested in the photograph of Thomas Guy's statue which is reproduced on another page of this issue. It will form the title picture of any films made at Guy's). And now we have television.

A course of medical instruction must not only provide for the inculcation of knowledge but must develop understanding, practice and confidence as well. Studies alone are barren. With Bacon we know that "the general counsels, and the plots and marshalling of affairs come best from those that are learned." The Guy's graduate enjoys a reputation for practical ability, common sense and resourcefulness. Is the current system of education furthering such a character? Judging by the performance of some of the dressers

and ward clerks at departmental rounds held over the last few months we are doubtful. For anyone who has recently embarked upon a clinical appointment to stand up before a visiting pundit or even before an audience at Guy's may at first be a little discomforting. The victims, moreover, are not specially selected beforehand—a commendable feature. But unless some improvement takes place soon it is to be feared that those surgeons, at any rate, who come from other hospitals will get a very poor impression of the type of man they find at Guy's.

Lack of knowledge is understandable. Inability to give a case-history briefly, clearly and without hesitation, or to conduct an examination of a patient systematically and intelligently is unforgivable. Furthermore, when a dresser is asked to give his diagnosis a mumbled recapitulation of all the signs and symptoms is beside the point.

There was, and in fact still is, at Guy's a tutor whose methods were martial and whose commands were peremptory. He did manage, nevertheless, to convince those who came under his supervision of the importance of taking a proper history, of making an orderly examination and of delivering a decisive statement of the findings. The pity is, perhaps, that he no longer fills his previous role. May we suggest, then, that even without such guidance students should develop for themselves the art of standing-up, speaking-up and shutting-up? To a few this comes naturally; to others only with practice. Not every teacher on the staff possesses this faculty. That is no reason for the student to be lacking. So versed and equipped and with all the other and newer methods of teaching to assist him—television being not the least of these—the Guy's graduate may still retain his pre-eminent position as a medical man in command of a situation instead of one who has simply collected a little information to be utilised under certain circumstances.

CONGRATULATIONS are offered to those who have lately gained appointment to the staff of the Hospital. In the Department for Skin Diseases, Dr. E. J. Moynahan becomes Assistant Physician. Qualifying from University College Hospital in 1934, he held house appointments there before entering the R.A.F. In that service he was a venereologist and was in charge of a dermatological unit. After 1945 he became an assistant to Dr. Dowling at St. John's, to Dr. Brian Russell at the Prince of Wales, and to the Skin Department of the King Edward VII Hospital at Windsor. He was awarded the M.R.C.P. in 1947, and since that date has been registrar in the Skin Department at Guy's as well as dermatologist to the Joyce Green and Orpington Hospitals.

During 1934–5, Dr. Moynahan worked at university clinics in Vienna and also at Prof. Leriche's clinic in Strasburg. In co-operation with the Bacteriology Department at Guy's he is now engaged upon research into the relationship between nasal staphylococci and furunculosis and, having a particular interest in physiological and biochemical aspects, he is carrying out investigations with the Department of Chemical Pathology upon the actions of the anti-histamine drugs.

Dr. A. M. Hutton and Dr. A. W. Hind have been elected Assistant Anæsthetists. Both are Guy's men. Dr. Hutton qualified in 1938, held various house appointments at Guy's and was a graded anæsthetist in the R.A.M.C. from 1941 until 1946, being mentioned in dispatches. Returning to Guy's he was a resident anæsthetist for a year and took his D.A., then becoming a Research Fellow of the Society of Anæsthetists. With Dr. Helliwell he was responsible for the study carried out at the request of the R.C.O.G. on the use of trichlorethylene in labour. He has also published a paper on anæsthesia in congenital pulmonary stenosis.

Dr. Hind qualified in 1941 and held house appointments at Guy's. In the R.A.M.C. between 1942 and 1947 he was a graded anæsthetist and in March, 1947, became an anæsthetic registrar at Guy's, taking his D.A. the same year. Research, with Dr. Harris, has been conducted on the pre-anæsthetic use of insulin and glucose to control ketosis, and on blood urea and amino-acid values in surgical anæsthesia.

THE visiting physician from America this year is Dr. Joseph Lilienthal, Jnr. As Associate Professor of Medicine at the Johns Hopkins Hospital he has worked with Dr. McGehee Harvey, who was at Guy's two years ago, and published work on D.F.P. and curare. His other interests include the physiological problems of aviation medicine. Travelling by air, Dr. Lilienthal is due to arrive in this country on June 1st, the same date as his surgical colleague Dr. Ravich, about whom an announcement appeared in the last issue of the *Gazette*.

Venous Thrombosis and Pulmonary Embolism

F. N. GLOVER, M.S., F.R.C.S.

DEEP vein thrombosis with the ever present danger of a fatal pulmonary embolus is a condition which develops in a variety of circumstances and, in spite of much investigative work throughout the world during the last decade, the exact causation remains unknown, so that the basis of treatment, prophylactic and therapeutic, has been built up from this uncertain knowledge. It is the intention of this paper to describe some of the recent work on this problem in an effort to rationalise therapy. The superficial and suppurative types of thrombophlebitis will not be discussed. Comparison of figures of the incidence of deep vein thrombosis are valueless unless the type of case, age and details of treatment are taken into consideration, but clinical and post-mortem figures agree that pulmonary embolism is more common in the medical wards. White and others showed that of 45,523 medical cases, 273 developed pulmonary embolism, whereas of 98,642 surgical cases, 238 showed embolic phenomena, an overall incidence of 53.4 per cent. in medical patients. In a post-mortem study, Hampton and Castleman showed that of 370 cases examined, 40 per cent. occurred in the post-operative period and after childbirth and 60 per cent. in medical conditions, of which one half were cardiac diseases. According to Swedish workers, untreated cases of deep vein thrombosis result in a mortality of 20 per cent. from pulmonary embolism and Welch and Faxon have shown that 25 per cent. of patients who develop a small embolic lung infarct will, if untreated, die later of massive pulmonary embolism, a figure which is comparable with the 30 per cent. quoted by Dickson Wright and the 20 per cent. by Gordon Murray.

Aetiology.

All published figures agree that age has an important bearing on the development of deep vein thrombosis and Allen gives the incidence as follows :—

Under 30	years—incidence	5.7	per cent.	
30–40	,, ,,	12.0	,,	
over 40	,, ,,	82.3	,,	including
over 60	,, ,,	38.5	,,	

The most important contributing factor is probably a sluggish venous return which may be caused by a number of different conditions. Pooling of blood in the lower limbs during operation, abdominal distention, tight and misplaced binders and the continued use of Fowler's position have all been awarded a portion of the blame. Flexion of the thigh on the abdomen slows the foot-carotid circulation time and, using radioactive sodium, may be shown that the foot-to-groin venous return is delayed by this manœuvre. Moreover, the " donkey " under the thigh slips to exert pressure on the popliteal vein and thereby plays its part. Debilitated patients suffering from anæmia, chronic infection and loss of weight and especially those with an alimentary neoplasm, patients with heart disease and elderly folk immobilised in bed for a long period by virtue of illness or accident are particularly liable to venous thrombosis.

Apart from slowing of the circulation, other changes in the blood in the post-operative period can be demonstrated. Plasma fibrinogen, after an initial fall, rises to double its normal level about the 4th day and remains elevated for a week, and Lyons postulated that the plasma fibrinogen B, increasing in parallel with the coagulation time, might indicate a pre-thrombotic state, a suggestion which requires further investigation. Shapero was able to show that the prothrombin level rises to a maximum by the 10th day, which may be an important feature in the clotting mechanism of the blood. For some time it has been known that the platelet count rises considerably after operation or tissue trauma and Payling Wright showed that the physical character of these cells was also changed in that they had an increased adhesive effect. Until the normal mechanism of blood coagulation is better understood the significance of these changes will not be fully appreciated.

Pathology.

It was commonly believed that, since embolism occurred most frequently after lower abdominal or pelvic operations and after parturition, the site of origin of the thrombus lay in the pelvic veins. Recent studies, however, indicate that in a very high proportion of cases the veins at fault lie in the muscles of the calf or foot. In Hampton and Castleman's series ante-mortem thrombosis in the leg or foot occurred in 95 per cent. of cases (excluding cardiac disease).

Barker, in a series of 1,665 cases of post-operative thrombosis followed at the Mayo Clinic, quotes 85 per cent. as having started in the veins of the lower extremity, and White's autopsy series on medical cases shows over 80 per cent. arising in the leg veins. Gunnar Baur of Stockholm, in 190 cases of thrombosis, states that only three started elsewhere than the leg veins and his concept of the pathology of this disease seems the most acceptable. He believes the clot starts in a muscular branch of a leg vein. By the simple process of accretion the clot propagates into the main deep vein and continues to grow in length cephalwards as an eel-like, dark, smooth, slippery, flagellating thrombus, at first attached precariously at its site of origin. At this point the muscular branch thrombus acts as an irritant, becomes firmly attached to the vein wall and will give rise to local tenderness, but the propagating thrombus in the main vein neither obstructs the lumen nor irritates the vein wall and is symptomless. It is, however, at this stage most liable to become detached and produce symptoms of pulmonary infarction. This process he estimates lasts 24–48 hours and thereafter the clot attaches itself to the walls of the main vein by means of an aseptic, inflammatory process which causes phlebitis and periphlebitis, spasm of the adjacent artery, obliteration of the vein lumen, œdema of the local tissues, congestion of the superficial veins, tenderness along the course of the vein and pyrexia. As the process advances the classical picture of phlegmasia alba dolens develops, with a white, swollen, cold leg due to arterial spasm and venous obstruction, and tenderness and pyrexia due to aseptic inflammation of the vein wall. The picture of "white leg" has long been recognised as evidence of deep femoral thrombosis, but it is not so generally appreciated that "cold whiteness" implies not only venous obstruction but also marked arterial spasm. Leriche pointed this out in 1934, suggesting the rational treatment by lumbar sympathetic injection with local anæsthetic and more recently Alton Ochsner and his co-workers in New Orleans have reiterated and enlarged upon this work. In a series of animal experiments they showed that by occluding a segment of vein between two ligatures, the accompanying artery went into moderate spasm. By injecting an irritant (sodium salicylate) into this occluded segment, the artery went into intense spasm, which could be relieved completely by novocain blockage of the sympathetic nerve of supply. Spasm extending to the arterioles caused capillary anoxia with increased permeation of fluid into the tissue spaces and a white, œdematous, cold leg. In another group of chemically induced thrombophlebitis with diminution of the calibre of the arteries, normal pulsation was regained after sympathetic block and, to complete the picture, clinical cases with the syndrome of "white leg" were markedly and rapidly relieved of pain and œdema by lumbar sympathetic block with procaine. Ochsner, too, was so impressed with the quiet thrombosis before inflammatory changes occurred—a phase of symptomatic silence, yet of dire danger because of looseness of the clot and liability to embolism—that he described two distinct types of thrombosis. The painful aseptic, inflammatory process he called "thrombophlebitis" and the quiet, propagating, loosely attached clot, "phlebothrombosis." Although this differentiation is widely used in many clinics and in articles on the subject, the majority view to-day is, as Baur describes, that they are phases in the consecutive process. Individuals will vary in the response they make to the stimulation of an intravascular thrombus. Some may show signs of inflammation so rapidly that the short phase of quiet thrombosis may be overlooked; others will show a minimal response to irritation and repeated embolic phenomena. Because of its potential danger, the clinician must be aware of this latter possibility.

Diagnosis.

It cannot be too strongly emphasised that the well-known clinical picture of "white leg" is a late and advanced stage of the thrombotic process. Much earlier diagnosis is required if the danger of pulmonary embolism and the development of the late sequelæ of œdema, eczema, ulceration or chronic venous insufficiency are to be prevented. A niggling, post-operative temperature, at some time described as the "little kick," is all that may be found. Allen stresses that a concomitant slight rise in the temperature, pulse and respiration rates with no signs in the legs or chest may mean venous thrombosis. Localised tenderness in the calf or foot muscles, with some dilatation of the superficial veins and minimal œdema of the overlying tissues is evidence of a localised thrombus. Homan's sign, pain in the calf on dorsiflexion of the foot, is almost diagnostic. Any pleuritic pain with blood stained sputum should be regarded as a pulmonary infarct following embolism. In spite of the plea of Cummine and Lyons to consider some lung infarcts as due to primary pulmonary vascular thrombosis, in the present state of our knowledge it is safer to regard such signs as a warning small embolus and act

accordingly. Incidence of early findings in 500 cases :—

(1)	Swelling with local tenderness	66 per cent.
(2)	Homan's sign positive	41 ,,
(3)	Minor pulmonary emboli	35 ,,

Phlebography in the early diagnosis has an inaccuracy of 30 per cent. and, in spite of Bauer's advocacy, is in general losing favour.

PROPHYLAXIS.

Prevention of venous thrombosis depends on the maintenance of an active circulation. Anything which allows or aggravates stagnation of blood in the veins predisposes to clot formation. Leg exercises and breathing exercises, taught to the patient in the pre-operative period, are encouraged as soon as consciousness is regained. A full range of foot and ankle movements is desired twenty times an hour and, in some clinics, the head of the bed is raised and a board placed at the foot of the bed so that, as the patient tends to slide downwards, he pushes himself back into a position of comfort with his feet, thus maintaining tone and active contraction of his calf muscles. Examination of the calves of all bed patients should be as much a daily routine as inspection of the temperature chart. The " donkey," the pillow under the low thigh and knee, is forbidden and with it the abandonment of Fowler's position which it was intended to maintain. Tight abdominal binders are forbidden and the legs, especially if varicose veins are present, should be kept bandaged. Where possible, intravenous therapy should be given into arm veins. According to the dictates of the individual case, proper early ambulation should be encouraged. This means " to get up, walk and lie down " and not merely to get out of bed into a chair. In that position with the legs flexed and dependent, circulation is sluggish and thrombosis invited.

TREATMENT.

Choice of treatment in thrombo-embolic disease lies between—

(1) Anti-coagulant therapy, heparin or dicoumarol.
(2) Interruption of the femoral vein, with or without phlebotomy and thrombectomy.
(3) Lumbar sympathetic procaine block.

Rationale.

Anti-coagulant therapy, by altering the normal intravascular clotting of blood, prevents extension of thrombosis, formation of new thrombus in other veins, secondary thrombosis in the pulmonary arteries distal to an embolus and reduces the incidence of emboli, large and small. It is to be emphasised that no change should be expected in a thrombus or embolus present before therapy starts.

(*a*) *Heparin.*

The exact mode of action of heparin is uncertain but it is believed to act principally as an anti-thrombin, though it probably also prevents the conversion of some prothrombin to thrombin. By phlebographic studies, Bauer has shown the thrombus does not propagate after the onset of heparin treatment. It is given intravenously as a continuous drip infusion in a solution of 5 per cent. dextrose or in divided doses throughout the 24 hours. Dosage is controlled by estimation of the coagulation time which should be kept at 15 to 20 minutes. The drug is rapidly destroyed in the body but in the event of overdosage and bleeding, this can be inhibited by the intravenous administration of 10 ccs. 1 per cent. solution protamine sulphate. Cases treated by heparin alone show excellent results. In Bauer's series of 209 cases, the mortality was 1.4 per cent., duration in hospital 4.7 days and incapacitating after-effects, none or very slight. Gordon Murray quotes the use of heparin in 400 cases prophylactically with no thrombosis or embolism, 371 cases of proven thrombosis so treated with no case of pulmonary embolism and late sequelæ markedly less than in the control group and, most dramatic of all, 149 cases of pulmonary embolism, of which 52 were moribund, treated with no loss of life, though heretofore one patient in every four surviving a first embolus would die of a subsequent one. Since heparin is expensive and requires intravenous administration, it is a more usual practice to initiate heparin and dicoumarol therapy simultaneously, withdrawing heparin when dicoumarol takes effect in 48 hours, as indicated by the increasing prothrombin time.

(*b*) *Dicoumarol.*

Dicoumarol acts by the prevention of synthesis of prothrombin by the liver. It is given by mouth, takes 48 hours to reach its maximum action and must be controlled by daily estimation of the prothrombin time. The dose is adjusted to keep the pro-

thrombin content of the blood at 30 per cent. normal. If this level falls below 10 per cent., bleeding may occur from granulating or unhealed wounds, the rectum, vagina or kidney, and red cells in the urine may be early evidence of toxicity or idiosyncrasy. The antidote is the immediate administration of 40 mgms. Vitamin K intravenously and a fresh blood transfusion. Figures from the Mayo Clinic show that in a control series of 678 cases of non-fatal, post-operative, pulmonary embolism treated expectantly without anti-coagulants, 297 (43.8 per cent.) had subsequent venous thrombosis, embolism or infarction and of these, 124 (18.3 per cent.) died. In 180 similar cases treated with dicoumarol, 2 cases (1.1 per cent.) developed subsequent thrombo-embolic phenomena with no deaths. Likewise, of 897 cases of post-operative thrombophlebitis, 95 (10.6 per cent.) developed further thrombophlebitis and 51 (5.7 per cent.) fatal embolism, whereas of 138 cases to whom dicoumarol was administered, 4 (2.9 per cent.) developed subsequent thrombophlebitis with no case of fatal pulmonary embolism. These figures are as striking as the results from heparin quoted by Bauer and Murray.

Interruption of the femoral vein.

Following the pioneer work of Homans in 1934, Allen, Linton and others at the Massachusetts General Hospital recommend femoral vein interruption as the safest method of prevention of pulmonary embolus, more particularly in cases of " phlebo-thrombosis " before the clot has become adherent to the wall of the vein and the danger of major embolism passed. Even in the painful " thrombophlebitis " they point out that a propagating thrombus can still occur and recommend vein ligation prior to relief of pain and swelling by lumbar sympathetic blocks. They advise exposure of the superficial femoral vein on both sides distal to its profunda branch, opening of the vein and sucking out of any contained clot before ligation and division at this level. Their indications are :

(1) patients who have developed a non-fatal pulmonary embolism, whether they have leg signs or not ;

(2) any patient who develops deep vein thrombosis, however minor the signs and symptoms ;

(3) any patients, post-operative or medical, with concomitant rise in temperature, pulse and respiration for which no other cause can be found ;

(4) prophylactic femoral vein ligation (bilateral) in patients over 65 years of age who are to be confined to bed for long periods by reason of accident or illness, or those over 50 years of age who are to be subjected to major abdominal or pelvic operation for cancer.

In support of their recommendations, they offer the following results of vein ligations. For the ten years 1937–1946, a total of 1,518 ligations were performed. 1,060 were following deep vein thrombosis or embolism and of these 53 (5 per cent.) developed subsequent emboli with 5 deaths, a mortality 0.5 per cent. 458 prophylactic ligations were carried out with 5 subsequent emboli and 1 death from embolism. 458 control cases with no vein ligation had 55 subsequent thrombo-embolic incidents and 26 deaths from embolism. With superficial femoral vein ligation, the disturbance of venous return from the limb, early or late, is minimal.

Lumbar Sympathetic Procaine Block.

For cases he designates " phlebothrombosis " Ochsner advises vein interruption, but for painful " thrombophlebitis " he has found lumbar sympathetic procaine block a most valuable method of relieving pain, reducing œdema, minimising hospital stay and preventing injurious after-effects. Mode of action has already been mentioned and the results are as follows :—

90.1 per cent. relieved of pain by 1st block.
99.0 ,, ,, ,, ,, ,, ,, 2nd ,,
56.0 ,, ,, ,, ,, œdema in 4 days or less.
additional 32.0 ,, ,, ,, ,, ,, ,, 5–8 days.
64.8 per cent. subsidence of fever in 48 hours.
additional 23.0 ,, ,, ,, ,, ,, ,, 5 days.
69.8 per cent. in hospital 4–8 days.
additional 19.0 per cent. ,, ,, 9–12 ,,

SUGGESTED TREATMENT.

From a consideration of the ætiology, pathology and response to various forms of therapy, the following suggestions are offered for the treatment of thrombo-embolic disease.

Prophylaxis as recommended in a previous paragraph should be practised.

In the early case of deep vein thrombosis with tenderness in the calf or foot muscles and perhaps a positive Homan's sign, anti-coagulant therapy should be instituted forthwith. Heparin 10,000 units (Toronto) should be given intravenously and thereafter 20,000 units in a litre of 5 per cent. dextrose by intravenous drip every 12 hours until the coagulation time reaches and remains at 15–20 minutes. Simultaneously dicoumarol should be started by mouth, 300 mgms. followed by 200 mgms. daily and controlled by daily estimations of the prothrombin content of the blood. When the prothrombin reading is reduced to 30 per cent. normal, the heparin drip is discontinued. With *adequate* anti-coagulant therapy, embolism seldom occurs and is practically never fatal. If there are contra-indications to the use of both anti-coagulants because of a bleeding tendency, recent operation with large raw areas or in patients, who by virtue of their disease must remain in bed for a long period, such as cardiac cases or thigh fractures in the elderly, then bilateral superficial femoral vein ligation below the level of the profunda branch should be performed after the vein has been opened and any clot sucked out.

In more advanced cases of thrombosis without pain but with swelling to the groin, anti-coagulant therapy remains the method of choice. If this type of treatment is contra-indicated and a warning embolism occurs, a high vein ligation of the iliac or inferior vena cava must be considered in spite of possible undesirable sequelæ.

For the painful " white leg " relief by lumbar sympathetic procaine block, repeated as required, may be quite dramatic, but should it fail or should embolism occur during this treatment, it should be abandoned and anti-coagulant treatment instituted. These two methods should not be used concomitantly because of the danger of severe retro-peritoneal hæmorrhage from the sites of needle punctures.

Whatever treatment is adopted, both legs should be bandaged with crepe or elastic bandages to reduce œdema and relieve pain; they should be elevated in bed and active movements of foot and ankles encouraged hourly. Measurement of the limbs daily gives some tangible estimate of progress. Careful check on fluid balance and reduction of sodium chloride intake will limit excessive œdema.

In the event of a massive pulmonary embolus with severe pain and respiratory distress, heparin 40,000 units should be given at once intravenously to prevent consecutive thrombosis, oxygen in high concentration by B.L.B. mask and block of the stellate ganglion on the affected side with procaine may relieve bronchial spasm, a possible factor in the immediate mortality.

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Music Club Concert

The Physiology Theatre was comfortably full on the occasion of the concert given by the Hospital Music Club on Wednesday, 18th May. A varied programme included works by Fauré, Mozart and Handel.

The choral rendering of the Fauré Requiem, lacking somewhat in soprano voices, achieved an unequal balance. Yet, for all this, the choir gave a very sensitive performance, while Miss Audrey Law and Mr. John Soothill were excellent as soloists.

Outstanding in the Mozart A Major Piano Concerto was Mr. Anthony Salmon. Never demonstrative, he blended his part with the orchestra as one feels Mozart should be played.

The final item, the Coronation Anthem by Handel, was a resounding success and served as an exciting conclusion to the evening's music.

Once again, Mr. Noel Nickson as the conductor is to be heartily congratulated. His effective discipline over both orchestra and chorus brought about that harmony that is so often absent from performances of this kind.

J.W.H.

Television at Guy's

THE television installation at Guy's is the work of Electrical and Musical Industries, Limited, who have designed and developed the apparatus in close co-operation with the Director of the Department of Surgery.

The possibilities of television as an aid to medical instruction have long been a matter for conjecture and, although on a few special occasions in America, television has been temporarily installed in an operating theatre to enable groups of surgeons to watch the performance of some particular operation, the present installation is the first properly engineered permanent equipment which, at every stage, has been designed to meet the particular requirements of the medical profession. This is, furthermore, the first apparatus of its kind in Europe.

At present the televised presentation of operations is still in a relatively experimental stage, but according to the engineers, definition is being improved and the technical problems involved in picking out in monochrome the different shades of tissue which an operation field displays, are being tackled successfully.

The Assembly.

The television camera is incorporated with the lighting unit so that the view obtained is very similar to that seen by the surgeon, and there is no departure from established theatre conditions or techniques. A surface reflecting mirror is mounted at the centre of the " Scialytic " lamp which utilises a 150 watt projector. In unit construction with this lamp are the lens complex and the television camera. The whole of this assembly can be rotated through 60° for operations on an inclined table or moved on an overhead track to allow flexibility.

The lens unit is motor operated from the control room and offers the choice of three magnifications.

POCKET CARTOON

by OSBERT LANCASTER

(With acknowledgement to the "Daily Express.")

" Of course, it's all terribly secret, and we must act just as though we knew nothing about it, but I rather think our appendix is going to be televised ! ! "

It is not a turret. The lenses remain fixed and the images are brought into alignment by small reflector assemblies.

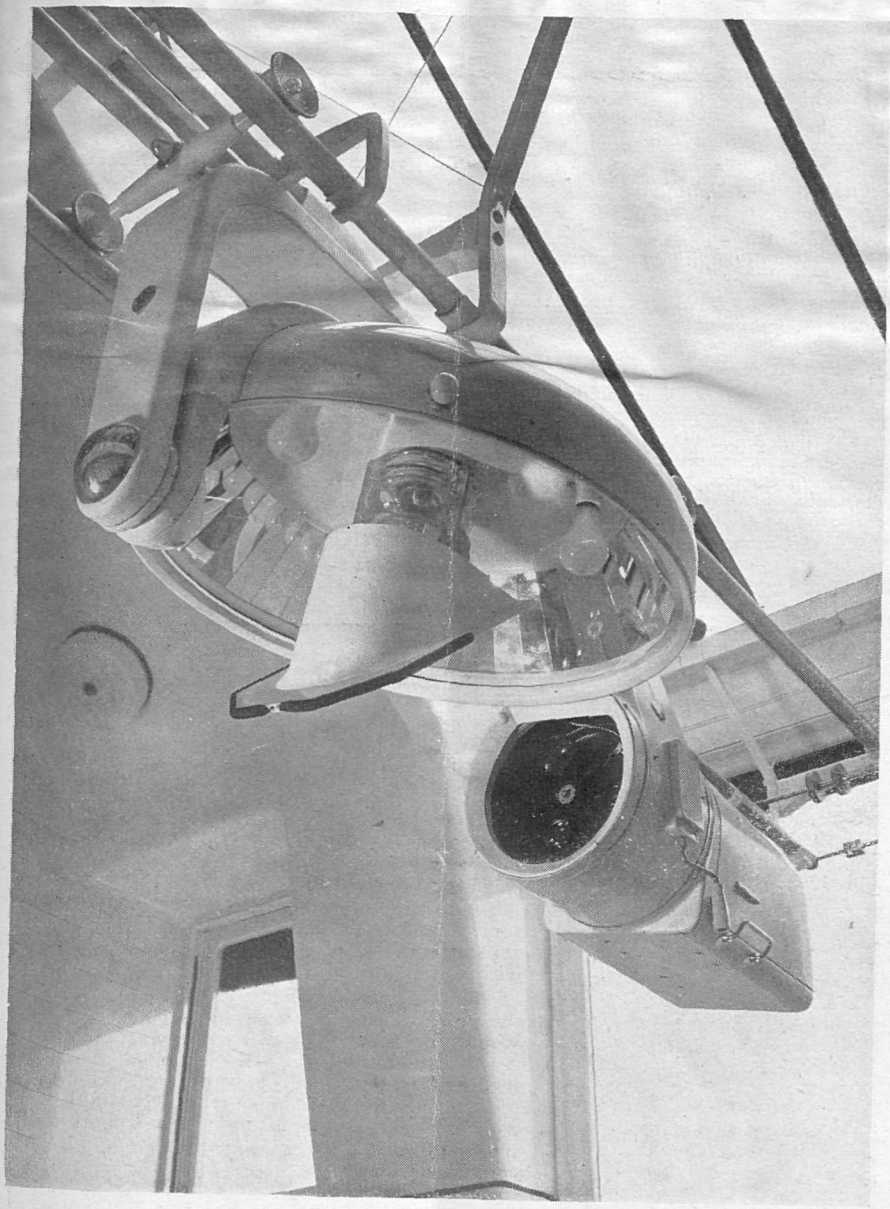
The camera employs a C.P.S. Emitron tube of high sensitivity. This, surrounded by the focus and scan coils, is mounted on a ball-bearing carriage which for optical focussing is motor-driven and remotely controlled. The head amplifier and line scan generator units are mounted alongside, accessible for maintenance and easily removable.

A microphone is incorporated to enable the surgeon to give a commentary and explanation of what he is doing. The camera, lighting, sound and control cables are all taken through telescopic tubes to the control point off the theatre gallery. The whole apparatus is enclosed and finished in conformity with normal operating theatre practice.

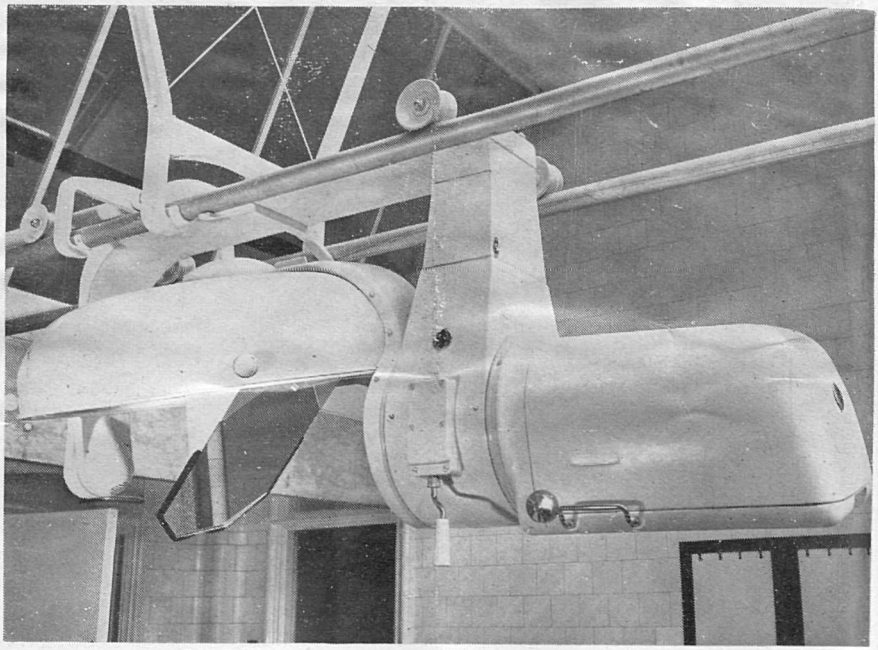
Vision equipment in the control room comprises the camera channel and waveform generator, whose various units are housed in reinforced sheet metal cases with removable sides, the components being mounted on hinged panels providing a high degree of accessibility for maintenance. Operational controls are grouped on the front panel and multi-way plugs and sockets are provided at the rear for interconnecting cables. In charge of this part of the installation is a departmental technician.

Special precautions have had to be taken to eliminate any possibility of diathermy interference from the large amount of electro-medical equipment in use in the hospital.

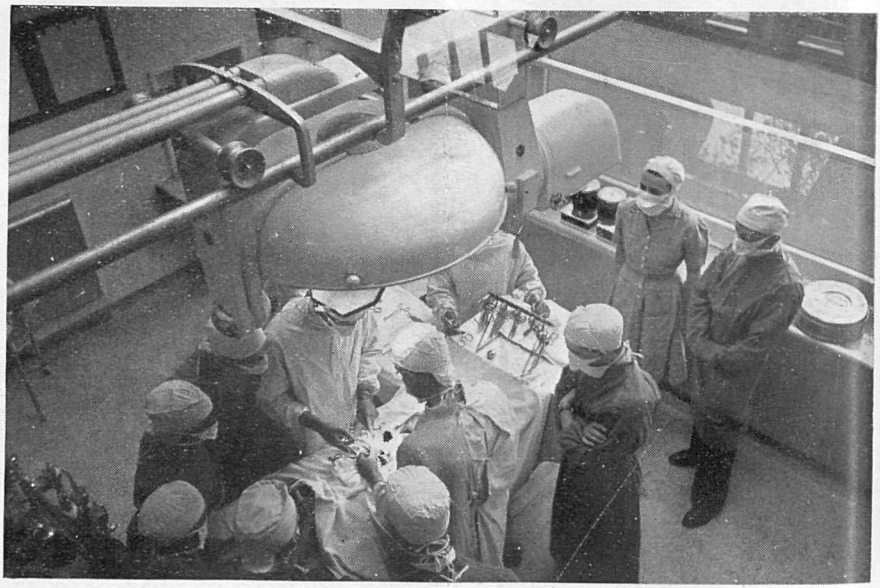
The equipment at present delivers television signals of the standard E.M.I. waveform 405 lines with 25 interlaced frames per second, but when required a higher definition standard of 605 lines will be made available.



THEATRE LIGHT, 1949



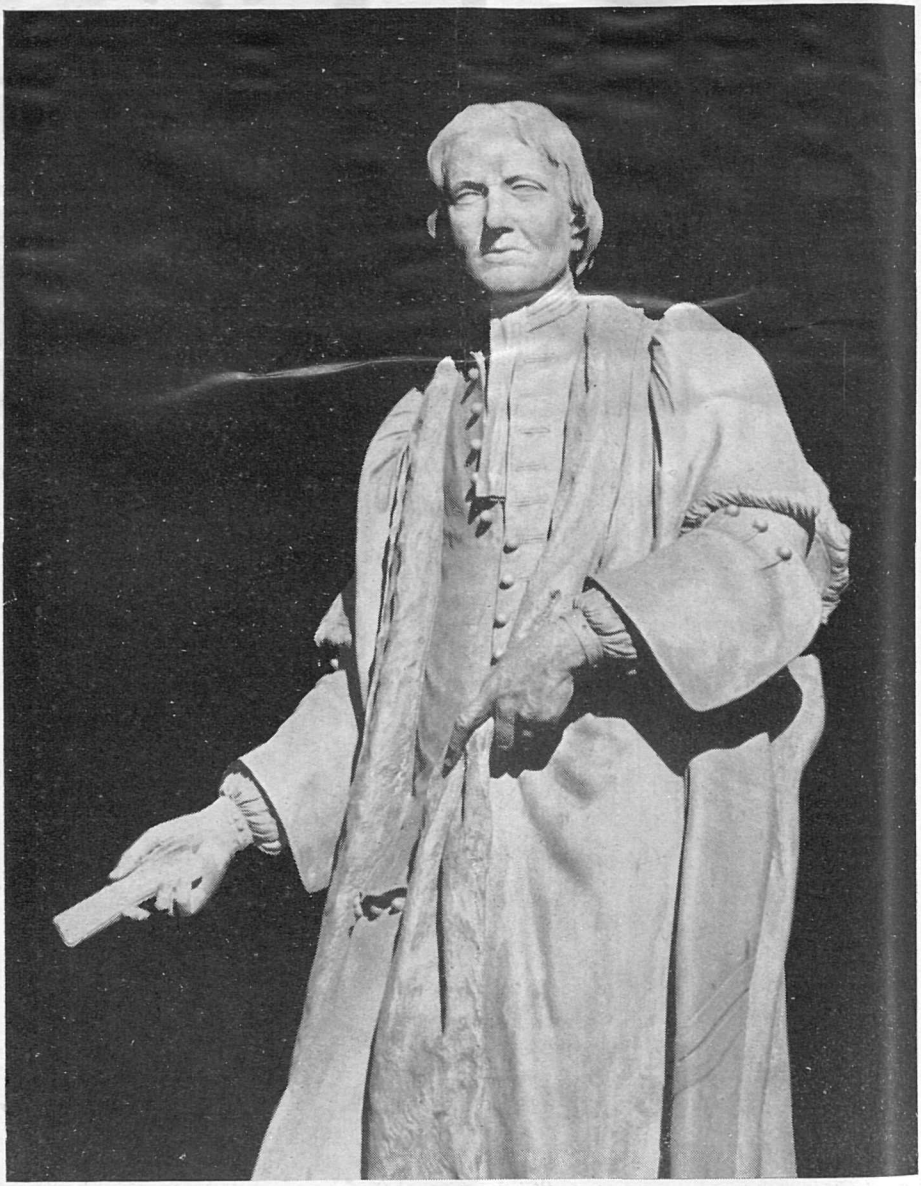
THE CAMERA



OPERATION IN PROGRESS

THE CONTROL ROOM

THE VIEWERS



Photograph by C. E. Eng

THOMAS GUY, 1949

Sound and vision signals are fed by cable to four viewing sets in the Surgeons' Room, in the Departmental Library and Exhibition Room, and in the Clinical Lecture Theatre. They are of standard HMV design with a 15 in. Emiscope tube, slightly modified to work on the signals received by cable. Provision is made for a demonstrator to supplement the surgeon's comments or, alternatively, to be responsible for the whole description of the operation; he may be in any of the viewing rooms and is able to select at will the most suitable size of field as the operation progresses.

The Purpose.

By means of this new installation a large number of people can now view an operation from a vantage point as good as that of the surgeon himself. The congestion in the theatre with spectators peering over each other's shoulders is avoided; the remoteness of the gallery seat is overcome. With comparative comfort viewers will see on the screen an operation area of 20 in. by 25 in., one of life-size or a magnified close-up of a field 5 in. by 6 in. At the same time the surgeon's observations will come over the speakers.

The system is designed particularly for post-graduate students who will thus be given instruction in surgery technique. Demonstrations by visiting surgeons will also be more effective with this new aid.

It is proposed shortly to invite parties of surgeons from hospitals throughout the country to inspect the installation and to watch televised operations; it is hoped that they will not only appreciate the value of this method in the teaching of operative surgery technique, but themselves suggest modifications and improvements, so that British surgery and its teaching will hold in the future, as in the past, its premier place in the world of medicine.

Obituary

Dr. ALFRED ALLPORT.

ALFRED ALLPORT died at Maidenhead on May 2nd, 1949, aged 81. He entered Guy's Hospital as a 1st year student in 1886 and he qualified M.R.C.S., L.R.C.P., in October, 1894. During these few years he was at the height of his athletic prowess, he captained the Hospital Rugby Football Club and played for England in nearly all the international matches in 1892, 1893 and 1894. He was an outstanding heavyweight boxer, being unbeaten in the Guy's and inter-hospital boxing contests; he also won the open heavyweight competition of the Orion Boxing Club, amongst other prizes.

His versatility is shown in that he took up rowing and in addition to reviving interest in this sport at the Hospital, he rowed in the Thames Rowing Club boat at Henley when they were beaten in the final of the Grand Challenge Cup by Leander in 1892.

Allport was keenly interested in all the social life at Guy's; it is even recorded that he served on a Committee to investigate complaints in respect of the College Catering in 1893.

Shortly after leaving Guy's he settled in practice in Milk Street in the City, where he remained until a few years of his death.

He always retained his interest in everything to do with Guy's and especially the Rugby Football Club. At the request of the Gazette Committee he compiled the history of the Club which was published in the special bicentenary number in 1925. He was an honoured guest at the centenary celebration of the Club at Honor Oak Park in 1943.

Thus another link with Guy's, of over 60 years, is broken as an old friend passes. Our sympathies go out to his wife and family who survive him.

W.D.D.

Founder's Day

A CONGREGATION representative of the Hospital gathered in the Chapel on Friday, May 6th, to commemorate our foundation by Thomas Guy. This date was chosen rather than January 6th, when in 1725 the Hospital was actually opened, because it was on May 6th, 1724, that " thanks were given to Guy for his unparalleled bounty in gifts to this Hospital and in erecting at his own charge another Hospital for incurables." Accordingly, the Governors have decided that May 6th shall be observed annually as " Founder's Day."

Our thanks are due to Mr. A. B. Kennedy, of the Board of Governors, for his generous gifts of flowers for the Chapel and to Mr. G. Gartside of Guy's Branch of the National Provincial Bank who kindly played the organ. We are also grateful to the choir of students and nurses who led the singing.

The Service was conducted by the Resident Chaplain and the address given by the Provost of Southwark, the Very Reverend H. E. Ashdown, M.A., Visiting Chaplain to the Hospital. We print below the substance of his address :

" His memorial shall not depart, and his name shall live from generation to generation."
Ecclesiasticus xxxix, 9.

I am sensible of the privilege I have in addressing you to-day and no less conscious of the inadequacy of my knowledge and experience for a proper discharge of my duty.

But I am very glad that the long and significant association of the Hospital with the Cathedral Church should have this recognition in to-day's revival of the Founder's Commemoration.

For the benefits to mankind which have sprung from the vision, the compassion and the generosity of Thomas Guy, we give thanks to God. In the honourable permanence of the name of Guy's we all hope that, in an obvious yet effective way, his memorial shall not depart and his name shall live. In the 1720's the gift of £19,000 for this building, and £200,000 for endowment, was such as to compare with those of a Nuffield or a Trent and lest we feel, shall I say, slightly embarrassed by the activities which made the benefaction possible, I would recall the name of a man to whom our Lord said : " To-day I must abide at thy house." It is not in the New Testament only that it has been said : " To-day is salvation come to this house." And my own conviction would be that of the house of Guy, the Great Physician said, " I must abide at thy house."

In the name of Thomas Guy we commemorate a great age and a great spirit. Throughout the 18th century the medical profession was moving out of the dark ages of traditional superstition into the light of science. Knowledge and devoted service in the " age of enlightenment " inspired tremendous advance in training and practice and this improvement in professional skill was supported and fostered by that remarkable age of foundations. Here in the capital, between 1720 and 1745, Westminster, St. George's, London and Middlesex Hospitals were founded, in addition to our own (across the road). In these foundations, as Trevelyan has written, " the age of philanthropy gave sober expression to its feelings, just as the age of faith had sung its soul into the stones of cloisters and cathedral aisles."

And all these were not municipal undertakings—they were the outcome of individual initiative and of co-ordinated voluntary effort and subscription.

It has been a notable characteristic of our history that, in the words of John Stuart Mill, " Nine-tenths of the internal business which elsewhere devolves on government, is transacted by agencies independent of it." In England the State has been fashioned and moulded by the community—and controlled by it—the community has counted for more than the State, and the individual for more than the community. The truth of Mill's dictum has now been qualified by the developments of the past half-century, but even in the new " Social Service State " into which we appear to be entering, it is a case of the State taking over in many, perhaps in most, fields the work which was begun or brought to completion by individuals or groups of individuals.

Our present system of education is founded upon the initiative and responsibility of a Bernard Gilpin in the 16th century and a Shaftesbury in the 18th century—grammar schools and charity schools founded by individuals and groups—such as those groups of merchants in Southwark whose vision and drive gave us the five foundations now united in St. Olave's.

Our health services derive from the great voluntary hospitals which developed so swiftly under the influence of individual compassion and co-ordinated voluntary effort in the 18th and 19th centuries.

Thus it is a spirit of adventurous social responsibility we salute in the person of Thomas Guy. And let us be certain of this : it is a spirit that is neither dead nor dying.

The Englishman's fundamental social instinct, the instinct to do things for himself, with others, and to build from below and not wait on directions, will find *fresh expression*, even if now, to a large extent, his activity and influence must be exerted indirectly. As Lord Lindsay has pointed out, it may be that the " Concern "—as Quakers call it—of the individual Englishman, his desire to do something for his fellows over and above what the law requires, manifests itself indirectly now, where in the past its influence was direct, and that the reformer to-day starts an organisation to prevail upon the Government to do what, a century ago, he would have done himself.

Ways still exist and, we hope, will always exist in England to check the pretensions of the State and assert the vigour of the community against it. And I think it probable that we are even now discovering new ways of asserting our individuality in a highly organised society. It is not without significance that the epic of Dunkirk was only possible because there are more Englishmen to-day familiar with the behaviour of boats in water than ever before in our history.

If I may be allowed to borrow from Sir Ernest Barker's " Character of England " : " It is possible to believe, if experience is any guide and if the innate characteristics of human-beings govern in any way their actions, that the essential quality of the Englishman, his passion for freedom and his unique capacity for living in a community without losing his personality (but rather increasing it) will assert itself even when the balance of material things seems to be against it."

" It is possible to hope that the Englishman will not turn his back altogether upon the past, and that the centuries of individual responsibility which have made him what he is will stand him, and the world, in good stead in the future. The forces that threaten the freedom of the individual are not confined to this country alone : they are part of 20th century civilisation."

" The question of how to reconcile the freedom of the individual with the claims of the community is a world question. May it not be that England holds in her hands the answer ? Far from being, as is so often asserted in these days, the outdistanced competitor in the race of history, the small, antiquated country obscured by the power of the giant communities of East and West, may it not be that England is the predestined mediator between the past and future ? "

" The earliest solver of the crucial problem which faces mankind to-day, she is still capable of solving it in its latest manifestations, provided only that she does not, by her own act, dry up the sources of her strength by weakening the sense of responsibility of the individual for his own acts and for his own future."

Let us bear from this commemoration the conviction that it is laid upon us to *make* traditions as well as to uphold them. Reforming enterprise and self-disregarding generosity we revere in the name of Thomas Guy. And though the changes of these present times may not appear friendly to the highest individual achievement, " The years teach much which the days never know "—as a wise proverb says.

The field of enterprise is not closed, though its boundaries have altered since the time of Thomas Guy, and as long as we enter it, to explore and cultivate, his memorial shall not depart.

Guy's Hospital Nurses' League

The 49th annual meeting and reunion of the Guy's Hospital Nurses' League was held on May 6th. Approximately 350 past members attended.

Prior to the meeting the usual service was held in the Chapel which was filled to capacity. Many people said they had never seen the Chapel looking so beautiful. The flowers were lovely. The Service was conducted by the Chaplain and the Provost of Southwark Cathedral gave the address; how well he expressed our thoughts of all that this day means to us.

The meeting was held in the Physiology Theatre by kind permission of Professor Spurrell. The platform had been transformed into a veritable garden of flowers, a setting suitable for the occasion. The Chairman, Mrs. Bulleid, extended a warm welcome to the members and introduced the Guest Chairman, Miss Marriott, who is now Matron of the Middlesex Hospital. The Matron, Hon. Secretary of the League, read apologies for absence from Lord Cunliffe, Mr. Doherty and several League members who also sent good wishes. Matron then presented the annual report and the balance sheet. Miss Marriott then presented the prizes.

EXHIBITION.

Plain Needlework.
Miss Duncombe
Miss J. Kennedy
Miss D. Smith

Fancy Work.
Miss Henry
Miss Henderson
Miss N. Williams

Knitting.
Miss Puddifoot
Miss Mumford
Miss M. Jones

Photographic Exhibition.
Miss F. Taylor
Miss B. Taylor
Miss A. Lewin

Arts and Crafts.
Miss Phillips
Miss Mutimer
Mrs. Humphreys

Special Prizes.
Miss Arter
Miss Tommis
Miss J. Kennedy

Dressmaking and Millinery.
Miss J. Hartog

Paintings and Sketches.
Miss M. Vick
Miss M. S. Griffith

Miss Marriott then gave a most interesting account of her work as a member of the North-West Regional Board. They appear to have made considerable headway and one felt very proud that she is a Guy's nurse. In her survey of the regional scheme, Miss Marriott said how fortunate the nursing profession is to have Matron as Chairman of the General Nursing Council at such a critical period. Few people realise what a tremendous task this is.

We were all delighted to see Miss MacManus on the platform and Miss Marriott paid tribute to her inspiring personality and great achievements in the nursing profession.

Matron then gave a short résumé on the Nurses' Bill now before the House of Lords.

Miss Addison proposed a vote of thanks to Mrs. Bulleid, Chairman of the League, Miss Marriott, Matron, Hon. Secretary, Mrs. Shackles, Hon. Treasurer, and to Miss Zygouras for all she does to keep the affairs of the League in order. Miss Jackson seconded.

At the close of the meeting a delicious tea was served in the Nurses' Home, and if the chatter and laughter were indicative of a good reunion this was certainly one of the best.

F.T.

Hopkinsiana

A classic event in the sporting world is shortly to take place. From all parts of the globe enthusiasts flock to the Johns Hopkins Hospital to watch a race embodying the quintessence of speed and grace. Under the ægis of the United Nations are gathered together in peace and amity competitors of all countries. We have just received an official entry form for the International Turtle Derby and Olympiad for 1949. To the fore as ever, Guy's is now entered for the field of turtle flesh. Unfortunately, rather a scraggy model, "Thomas Guy," is representing us this year. Next year our stables hope to have a new, streamlined, turbo-jet animal incorporating an automatic alarm clock and transmitting set.

Adequate description of the DAY is impossible in so short a space. Suffice it to say that it is colourful, tense and spirits rise towards nightfall. Rules are severe and penalties heavy. Any use of dope, mechanical stimulation or any of the newer hormonal preparations is regarded as crooked. Sex appeal is considered particularly reprehensible. Needless to say such laws are venerated more in breach than observance. Those who are familiar with the American Radio will no doubt have heard the singing commercial advertising the new hormone Testudone, given as an injection. (By a sweet, young thing, to the tune of Londonderry Air) :—

Hopes not furtl ?
Just one squurtl,
See your turtl
—home.

(*With apologies to that old Hopkins graduate, G. Stein*).

On May 27th, at about 3 a.m., we shall see these highly-strung creatures waiting in their paddock bedecked in the gay colours of their owners. Professors, surgeons, nurses and students are all arrayed in " immaculate " attire. They stand by their steeds well-lubricated and in excellent fettle. Interference with one's own or another turtle is strictly forbidden, including upsetting (turning turtle) and the use of decoys (mock turtles).

Enough has been said ; the rest can be left to the reader's imagination. We only hope it will stimulate his interest in turtlemanship. We look forward to the day when we are allowed to see one of these spectacles at Guy's (provided free by Mr. Bevan). In the meantime, to what better use could our new television be put than viewing OUR turtle.

STRICTLY ANON.

Mr. Atkins writes : " I have cabled the organisers asking permission to enter the famous turtle " Thomas Guy " for this event, who will be painted in the Guy's colours, and I am arranging for the transfer of dollars to cover the entrance fee for this fine animal."

" I am sure that all Guy's men, past and present, will wish " Thomas Guy " good luck, and although we cannot be at the winning post to cheer him on, we can rest assured that he will have the sympathetic support of a friendly crowd."

Reviews

Enuresis or Bed-Wetting. By R. J. BATTY. 2nd Edn. Staples. *Price* 9*s.* 6*d.*

Although this monograph contains some interesting information concerning a difficult subject, it suffers from a general lack of clarity and conciseness. The chapters on anatomy and physiology are much too contraversial to be really helpful, and the discussion on causative factors seems to lead to no very definite conclusions. The best sections are those dealing with the cure and reasons for failure, but they could have been improved with a more critical approach.

M.J.P.

Gas and Air Analgesia. By R. J. MINNITT. 4th Edn. Bailliere, Tindall & Cox. *Price* 5*s.*

This little book is positively topical at the present moment. Used correctly, gas and air analgesia is a boon both to the patient and to the obstetric attendant. Thrown at the patient it is no more use than any other missile might be. Here, in clear and concise form, is a handbook concerning its use. It is worth reading.

H.A.R.

Medical and Nursing Dictionary and Encyclopædia. By EVELYN PEARCE. 9th Edn. Faber & Faber. *Price* 17*s.* 6*d.*

This ninth edition of Miss Pearce's book, already well-known to members of the nursing profession, needs no further introduction.

As suggested by the title it is a comprehensive volume, including many aspects of treatment and nursing. Some treatments appear a little out of date, an example being the method described of giving an intravenous infusion.

It is inevitable that even so recent a publication will be dated by its definition of " Hospital," which under State Service is no longer applicable.

This addition will be welcomed by senior and junior nurses for its concise definitions covering a wide field, making it valuable for rapid reference. P.H.M.

Correspondence

Television.

SIR—Many of us will have read with interest the account in the daily press of the first use of television for demonstrating a surgical operation at Guy's. This is doubtless an important technical innovation and should come to play its part in the training of *graduates*, although it can never rival in value or replace their active participation as assistants in the surgical procedures which help to fit them for their specialist craft. On occasions it will enable a large audience to see and hear a great master at work.

It is very much to be hoped, however, that the innovation will not lead to *undergraduate* students spending—I fear I must say wasting—any more of their time watching operations in a new and indirect, if more comfortable, fashion. The great majority of students are going to be general practitioners and the need for training more and better practitioners as well as for giving them better conditions of work, was never greater and must increase rather than diminish with the multiplication of specialists. Already they are subjected to far too much specialised and technical instruction. In the case of surgery (if we except such minor and emergency operations as any doctor may be called upon to perform), what they most need to acquire is, surely, not technique but an understanding of how to separate those conditions which must be surgically treated, those conditions which sometimes require surgical treatment after thoughtful enquiry and consultation, and those conditions in which surgery is scientifically and ethically unjustified. They must also be better informed about the final results of given operations (whenever possible with statistical support), both in respect of their functional results and (in major surgery) in respect of operative mortality and probable expectation of life.

Watching operations directly or on the screen may engender admiration for a skilful pair of hands and a desire to emulate an able chief, but it does nothing to develop powers of judgment. In common with many other physicians, I have never seen an operation on the heart or a lobectomy, and I could count on two hands the gastrectomies and major neuro-surgical operations at which I have attended. Looking back on experience, I can find little to suggest that my medico-chirurgical judgment suffered from these omissions. Careful clinical and pathological assessment, a knowledge of the patient as a person, of his main circumstances, and of his surgeon can be as important as delicate technical procedures. Social rehabilitation after major surgery is another important concern of the patient's own doctor.

Yours, etc.,

JOHN A. RYLE.

Oxford.

What is the Meaning of This?

SIR,—I am interested in your correspondent's letter criticising the pictorial decoration of the new students' common room. Was he not looking at it with a too matter-of-fact eye? The placing of a frame around it is misleading as it tends to the illusion that it is a *picture*, whereas surely it was commissioned as a *mural*; a type of painting wherein there is no centre of interest but a series of scenes painted usually in a purely decorative style.

Has the artist worked under great difficulties, *e.g.* committees, which have resulted in the inconsistencies which are so apparent? Whereas many of the scenes, glimpsed between the columns, *e.g.* the rugger field, are delightful little pictures in themselves, they are treated far too naturalistically for a mural and are quite incongruous with the unpleasant and unnatural lemon yellow arches which assail the eye. Would not a cool grey have provided a more pleasant background and been in keeping with the naturalistic style which presumably the artist has been forced to adopt?

Perhaps the skeleton at the end is not the patient about whom J. G. Armstrong is so concerned but all that remains of the artist after wearing arguments with warring factions.

Yours, etc.,

"JOAN NORDLAW."

Guy's Hospital, S.E.1.

The Museum.

SIR,—Some attempt has evidently been made recently to restore the wax models of skin lesions in the Museum to some sort of order—but it seems a very queer sort of order to us.

The uninitiated who have not discovered the catalogue (behind the 3rd jar on the left on the centre table if no one's moved it) have no means of knowing where anything is except by plodding steadily through the whole collection—is there a method ?

Even with the catalogue, No. 1 must be located and is in the most unexpected place—why not by the entrance where you come in ? But having found it you see measles, syphilis, and pemphigus apparently grouped together. This, though, is the sort of accident which continually occurs as the numbers run *round* the room affording the student plenty of exercise. They do not even run round the room logically but stop and start and miss out tables in the most whimsical way.

If these models are for teaching purposes, could they not be put in some comprehensible arrangement and augmented with clinical and microphotographs, etc. ?

If they are to be kept in their historical positions (presumably this is the excuse for the present arrangement) surely it is a criminal waste of space in the Museum of a teaching hospital ?

Yours, etc.,

"TOM, DICK & HARRY."

Guy's Hospital, S.E.1.

Night Lights.

SIR,—Whilst I was a patient in Miriam Ward, several patients and I complained about the new lights at night. The white and yellow lights, especially when you are just going to sleep, shine right into your eyes and light up the whole ward.

I suggest that the white light be replaced by a dark blue one, and the yellow one by a dark orange one.

Yours, etc.,

DEREK FORREST.

Guy's Hospital, S.E.1.

Guy's Diary

MAY-JUNE

ACADEMIC AND SOCIAL

May

Exhibition. Surgical Dept. "Swellings of the Neck."

23rd. 1.00. Professor M. A. Rushton. Clinical Lecture. "Some Mandibular Deformities."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

24th. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.
8.15. Residents' Play, 1949. Physiology Theatre.

25th. 8.15. Residents' Play, 1949. Physiology Theatre.

26th. 12.00. Mr. L. Willmore. Dental Clinical Lecture. "Abnormal Speech : Problems and Treatment." Dental Theatre.
1.00. Mr. Glover. Clinical Lecture. "Further Experiences of American Surgery."
4.30. X-ray Meeting. Gordon Museum
8.15. Residents' Play, 1949. Physiology Theatre.

27th. 1.00. Professor A. Bradford Hill. Clinical Lecture. "Statistics in Medicine II."
2.15. Medical Dept. Combined Round. Preclinical Classroom.
8.15. Residents' Play, 1949. Physiology Theatre.

28th. 10.00. Surgical Dept. Clinico-Pathological Meeting. Anatomy Theatre.

30th. 1.00. Mr. Blaikley. Clinical Lecture. "Post-Maturity."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

31st. 1.00. Dr. Baker. Clinical Lecture. "Pericardial Disease."

June

2nd. 4.30. X-ray Meeting. Gordon Museum.
7.30. Students' Union Dance, Victoria Hall, W.C.1.

3rd. 2.15. Medical Dept. Combined Round. Preclinical Classroom.

6th. 12.00. Surgical Staff Conference. Clinical Theatre.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

MEDICAL SCHOOL

Applications are invited for the appointment of **Junior Assistant to the Director of the Department of Medicine.** Duties to commence as soon as possible. Applicants should hold a higher qualification. Appointment will be until 30th September, 1949, in the first instance. Salary £750, plus superannuation and family allowance.

Forms of application obtainable from the Medical School Office and should be lodged with the Dean not later than 26th May, 1949.

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

SECOND EXAMINATION, MAY, 1949.

S. F. Mitchell
R. F. Poole
E. G. M. Stillwell
A. V. Westlake

Old Regulations.

M. E. S. Bathurst
D. London
N. J. Mayson
W. D. V. Ryan
J. J. F. Staub
C. A. P. Steele
A. H. Whitaker

OXFORD UNIVERSITY

Bachelor of Medicine.

The degree of Bachelor of Medicine has been conferred on A. C. M. Mann.

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

April, 1949.

Pathology, Bacteriology and Forensic Medicine : E. T. King.

Midwifery : M. P. M. Coupland.

SQUASH

Students are reminded of the following rules with regard to the booking of squash courts in the book provided in the College :—

(1) Courts may not be booked more than three days in advance.

(2) The names of both players must be entered.

(3) When a court is booked it must be taken up ; but if for any unavoidable reason the players are unable to do so, their names should be cancelled immediately in the book to enable others to play in their stead.

(4) No one name may appear more than twice in the same three days.

LAWN TENNIS

On Wednesday, 11th May, a match was played at Walthamstow between the Women Students of Guy's and those of the London Hospital. Guy's won by 5 matches to 4, the team being as follows :—

Sheila Mulally, Sheila Evans, Pamela Ordish (Capt.), Nora Williams, Diana Surtees, Prudence Bellam.

APPOINTMENT

Professor R. R. Macintosh has been appointed a member of the Medical Research Council to promote research into analgesia suitable for use by midwives.

PAPERS BY GUY'S MEN

Allsopp, C. B. Radiation Chemistry. *Brit. J. Radiol.*, 1949, **22**, 183.

Cardew, P. N. A Hospital Photographic Department. *St. Mary's Hosp. Gaz.*, 1949, **55**, 68.

Clarence, P. S. Synthetic Fillings : Holding the Matrix. *Brit. Dent. J.*, 1949, **86**, 230.

Cole, P. P. and Another. The Treatment of Cavernous Hœmangiomas and Cirsoid Aneurysms by the Injection of Boiling Water. *Brit. J. Surg.*, 1949, **36**, 346.

Hardwick, C. Ascites. *Clin. J.*, 1949, **78**, 93.

Hardwick, C. Ascites. *Brit. Encycl. Med. Pract.*, 1949, *Int. Suppl. No.* 80, p. 3.

Macintosh, R. R. Death following injection of Neostigmine. *Brit. Med. J.*, 1949, i, 852.

Reeve, E. B., and Another. A simplified method for the determination of circulating red-cell volume with radioactive phosphorus. *J. Physiol.*, 1949, **108**, 12.

Correction.—Batchelor, J. S. The reference quoted in the last issue should have read : *Brit. Encycl. Med. Pract.*, Interim Suppl., 7x, 1949 (April), p. 9, and not 1947 as inadvertantly printed.

CHANGES OF ADDRESS

N. Gillman, M.B., B.Ch., 16, Acacia Avenue, Birstall, Leicester.

K. G. B. Pritchard, L.D.S., R.C.S. (Top Flat), 68, Hazlewell Road, Putney, S.W.15, and 36, Queen Anne Street, W.1.

L. J. Wallace, L.D.S., R.C.S., 25, Stafford Terrace, Kensington High Street, W.8. (Tel. : Western 9466.)

MARRIAGES

PRITCHARD—McCANN.—On Friday, April 22nd, 1949, at Portrush, Northern Ireland, K. G. B. Pritchard, L.D.S., R.C.S. Eng., to Elizabeth H. McCann, S.R.N.

SUNNER—ENGLAND.—On April 30th, 1949, at Shirley Methodist Church, Alan H. Sunner, M.C., to Maureen England, S.R.N.

BIRTHS

EVANS.—On May 11th, 1949, at Nuffield House, to Winifred (née Groom), wife of M. L. Hudson Evans, M.R.C.S.—a sister for Timothy (Sara).

SPILLER.—On May 4th, 1949, at Barton House, Halstead, Essex, to Joy, wife of J. G. Spiller, L.D.S.—twin sons.

TIBBS.—On March 27th, 1949, to Paddy (née O'Meara), wife of D. J. Tibbs, M.C., F.R.C.S.—a son (Brendan Paul), brother for Teresa and Nigel.

TRETHOWAN.—On May 15th, 1949, at Nuffield House, to Daphne (née Isitt), wife of John Trethowan—a daughter (Jane Evelyn).

DEATHS

ALLPORT.—On May 2nd, 1949, Alfred Allport, M.R.C.S., L.R.C.P., of 31, Fitzroy Road, N.W.1.

WARNER.—On April 19th, 1949, at the Devon and Exeter Hospital, Harold Percy Warner, M.R.C.S., L.R.C.P., aged 63 years, of "Rydal," Woodford Green, Essex.

Eds. { H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXIII. No. 1588 *4th June* 1949 *Ninepence*

PASSIM

FILM reviewing, in a general sense, is no function of a hospital journal. "The Snake Pit," now being exhibited in London, nevertheless has a particular interest for the medical profession and the fact that it has already excited some controversy should justify its consideration in these columns. Based on a novel intended to disclose the appalling conditions in certain mental hospitals of the U.S.A., the film is shown in this country somewhat out of its proper context. A careful attempt must therefore be made to judge it strictly on its own merits.

The distributors have declared "the film will not be advertised to the public in any sensational manner" and, despite the suggestive title, they have observed unusual restraint in this respect. The same can scarcely be said of the press at large. Even the crowds at the cinema doors are entertained by a sinisterly unctuous individual touting the current edition of a well-known illustrated magazine revealing "the truth behind it all."

Of the film itself we can say at once it is not "horrific." Indeed, it deals with its subject in a most sober manner. Admittedly the psychological theme is over-simplified—what else could one expect in a general release? Granted, too, there is an appeal to the more tender sentiments—that is how Hollywood caters for its public. For all that, the ultimate effect upon the audience was one of deep impression. They left at the end in a mood of quiet reflection. Possibly they gained an exalted estimate of the psychiatrist's powers and a disproportionately poor opinion of the nursing staff's understanding but there was no gloating. Absent was that sadistic pleasure derived from so many films, ostensibly less dangerous in purport yet so evil in effect. The British public is by no means stupid. It will ascribe the wilder scenes to Hollywood's natural exuberance and then think calmly about conditions over here.

Contemporary comment is therefore of vital import. And what do we find? The daily papers announce in formidable headlines, "No nurse in ward for 80," "Asylum staff do as they like," and so on. The film is of sufficient integrity to constitute no danger in itself; the foreword sets the right note from the start. But topical reporting and news exploitation may lead to a misconception of the provisions made in Britain for the mentally afflicted. This must be countered.

Unfortunately, the psychiatrists seem on the defensive whenever the film is mentioned. Endorsing it as true of "certain groups of mental hospitals in the U.S.A." they proceed to assert that "it can do little but harm to the mental policy of this country." If, indeed, there are beams in our neighbours' psychotherapic eyes may there not well be a few motes in our own?

In a parliamentary reply the other day the Minister of Health stated, ". . . in London and the Home Counties . . . the accommodation in use (for mental illness) is overcrowded by 4,048 beds—approximately 11 per cent. of the total. The proportion of bed space available but not being used through lack of staff is 4.1 per cent." The arrangements prevailing in "one of the leading mental hospitals" were, according to an anonymous, voluntary ex-patient writing in *The Lancet* some time ago, nothing short of disgraceful. Furthermore, Dallas Pratt, making a survey in 1947 of sixteen English public mental hospitals on behalf of the American National Mental Health Foundation, conceded that, on the whole, standards here were better than in his own country but reported, none the less, adverse findings of some gravity.

To dismiss this problem as one for experts or, maybe, royal commissions is to avoid the issue. It directly concerns the medical man and the medical student. We do not presume to offer a solution in a few phrases. Instead, we may mention various points which have a certain relevance. Mental disease can be regarded under three headings:

mental deficiency, major psychological illness and minor psychological disorders. For centuries, some provision has been made officially for the first of these and also for a number of cases falling into the second category. The so-called "lunatic asylums" afforded refuge and public protection. Those concerned with the management of these institutions, from being mere warders, in time became naturally the specialists in mental disease. As knowledge advanced and the lesser deviations from mental normality came under recognition and diagnosis the members of the profession to whom they were referred were those who had gained their experience in asylum practice. If, then, a patient failed to respond to the suggestive influence of his own doctor practically the only alternative, by way of specialist care, was to enter one of the local authority institutions.

What is so regrettable is that the trend in modern medicine tends to accentuate rather than eliminate this division. Excessive departmentalism is to blame. "The detective side of medicine—investigation and diagnosis—has such charms that many doctors never get over their early preoccupation with it. Treatment makes a poor second." Thus ran a leading article a few weeks ago. Reference to the questions set at the last London M.B. examination suggests that the student gets no option. The various specialist units, multiplying with remarkable prolificacy, develop the most ingenious aids and devices to ensure accuracy and precision in diagnosis. In these the student becomes well-versed—it behoves him to do so. The complexities of the signs of cardiac disease form an elaborate pattern. Care of the patient involves a spell in hospital and then—well, a different, or a light job! Unravelling a neurological problem is at once fascinating and logical. Treatment, though, is so often of limited efficacy and no more than empirical. Again, the catalogues in the Gordon Museum are silent witnesses. Case after case is reported in which the patient has undergone a sequence of remedies and operations, all to no avail. Then, with the removal of that part preserved in the bottle "recovery was uneventful and satisfactory." But, one wonders, for how long? Until discharge from the hospital or just over that period intervening between operation and the compilation of the record?

Surgery, equally with medicine, is concerned with living people, at least in the first instance. Specific treatments, even to-day, are few. Each patient presents "a psychosomatic problem," to a greater or lesser extent. After discharge from hospital, or simply from the doctor's consulting room, that person must adapt himself "to live a life useful to the community and satisfying to himself." What happens all too frequently is that the organic lesion is dealt with and if the rest of the patient thereafter fails to respond accordingly some other specialist is called in. Often this is the psychologist.

The plea then, once again, is that the patient should be treated as an individual and not just a case; that, as Dr. Todd has emphasised, perhaps not very convincingly in his new book, the symptoms must be alleviated as well as the pathological process arrested. Psychotherapy must be combined with the other, more mechanistic measures from the outset, not invoked as a last resort. Means for achieving this mental as well as physical reablement must be available throughout the country at centres apart from "asylums" or "mental hospitals." Best of all, the general practitioner should play his part in encouraging recovery in this way. Even at Guy's, where a psychological unit exists without the old local authority stigma, there is a repeated insistence that some psychological abnormality is "not a medical matter." The old family doctor did not confine himself to the writing of prescriptions. He made it his business to understand the domestic and social relationships and difficulties of those who came to seek his advice, so that he could help them in all respects. For this reason the student, in his three-months' psychological clerkship, must become acquainted, not only with the labelling of the mental illnesses which he sees but also with the methods adopted to cure them.

In this way doctors may be trained who, in the course of their general practice, are able to treat their patients psychologically as well as medically without the assistance of a specialist. The damning diagnosis of "neurotic" may then never arise, at least overtly. Chronic mental disease demanding expert attention should, of course, be dealt with at an appropriate centre. But the emphasis must then be on therapy and re-establishment, not on asylum. Finally, for those poor creatures so stricken in mind that the future offers no hope and whose presence is upsetting to others, segregation is inevitable. An ideal plan demands more buildings, more apparatus, above all more staff and certainly more time. Apathy is inexcusable. Only by constant awareness and striving will a state of affairs be attained in this country free from any risk of that censure which is implicit in the film to which we have referred.

Sleep and Insomnia

By K. S. MacLEAN, M.D., M.R.C.P.
Assistant to the Director of the Department of Medicine.

THE problem of insomnia must be one of the most frequent with which a medical practitioner is called upon to deal and the success of treatment largely depends upon the doctor's ability to discover the cause in each individual patient. It has always seemed to me that disturbance of sleep is a subject which hardly receives the attention it deserves in the present day medical curriculum, and I feel that it is one which will repay more detailed consideration. I shall first consider the physiological changes which occur during natural sleep and summarise briefly the various theories which have been suggested to explain this interesting, yet little understood, condition. We shall then be in a position to discuss the various types of insomnia and the correct treatment for each case. Finally, the different kinds of pathological sleep will be considered.

PHYSIOLOGICAL CHANGES IN SLEEP.

As might be expected these tend to be most marked during deep sleep.

The body temperature falls a fraction of a degree, the pulse slows 10 or 15 beats per minute, and the respiratory rate is also somewhat depressed and may show a tendency to become periodic.

Most of the metabolic processes are retarded and basal metabolic rate estimations show a value of minus 15 per cent.

The digestive processes provide an exception, for these are little, if at all, affected and indeed the stomach may show very active peristaltic movements. The secretion of saliva is, however, diminished.

The amount of urine secreted is also low, although the waste products of metabolism are cleared by the kidneys much as usual with the result that urine secreted during sleep is of a high specific gravity.

Sweating, on the other hand, is increased and may be markedly so, so that this method of excreting fluid becomes very much more important than under normal waking conditions.

The blood pressure falls, the systolic reading being reduced by as much as 30 mm. of mercury. During disturbing dreams, however, a very different state of affairs may exist and normal people in these circumstances have been shown to have a systolic pressure as high as 200 mm. of mercury. In hypertensive subjects the sudden rise of blood pressure in such circumstances may lead to a cerebral catastrophe and either hæmorrhage or thrombosis may occur during sleep. Although Walshe believes that both these disasters occur when dreaming causes the blood pressure to rise, it seems to us more reasonable to assume that it is the normal fall in blood pressure during deep sleep that paves the way for thrombosis to occur, while a sudden increase will, of course, give rise to conditions favourable for hæmorrhage.

On examination of the central nervous system it is found that the pupils are contracted but retain their reaction to light. The knee jerks are frequently lost and the plantar response may revert to the extensor type.

THE DEPTH OF SLEEP.

The accurate recording of the depth of sleep is a matter of great difficulty, and the methods employed can only be described as rough and ready. These consist in observing all movements made by the sleeping subject on the assumption that these will diminish as the depth of sleep increases or alternatively in measuring the intensity of an auditory stimulus necessary to cause awakening.

Using these methods it has been shown that the depth of sleep increases steadily during the first hour, then lessens sharply, after which it continues to decrease although at a very much slower rate until waking occurs.

In children there are two periods of really deep sleep, initially as in adults at the end of one hour and subsequently when the child has been asleep for some seven or eight hours, after which the depth decreases rapidly until waking occurs.

As a general rule sleep taken in the daytime is never as deep as that at night. This may not, however, be true for night workers who have become so used to sleeping by day that the whole sleep cycle is reversed, but shift workers may suffer considerably from inadequate sleep.

Various types of stimuli have very different effects upon sleepers ; generally speaking an olfactory stimulus will have little tendency to cause awakening, as shown by the ease with which people may be accidentally overcome by coal gas during sleep, while auditory and painful stimuli have a much greater effect. The way in which one special sound can be singled out as an alarm is well known : a good example being the mother who will sleep peacefully while trains rush past the window, but will awake at once should her baby cry.

Unfamiliar sounds have a much greater effect upon the sleeper than well recognised and familiar ones.

SLEEP REQUIREMENTS.

Different people require different amounts of sleep and the amount required decreases throughout life. A new born infant requires twenty hours in the day, an adult about eight and the aged as little as five or six. It therefore appears that the amount of sleep required bears a direct relationship to growth and activity.

Lack of sleep may produce serious symptoms including unsteadiness, loss of muscle tone and a diminished threshold to pain. Finally severe physical exhaustion and death may occur. It is not known how long man can survive without sleep, but experimental work has shown that in dogs a period of fourteen days may prove fatal.

THEORIES OF SLEEP.

Many theories have been put forward to explain the physiological basis of sleep. Perhaps the earliest of all postulated that sleep was caused by lack of blood supply to the brain. This was founded on the observation that pressure on the carotids might cause unconsciousness. Although this theory did nothing to further our understanding of the nature of sleep, as in the first place the unconsciousness so produced was not sleep but coma, and secondly, accurate observations recently made on sleeping subjects have shown that the blood supply to the brain hardly alters in amount, it did leave its mark on anatomical nomenclature by suggesting a name for the main artery to the head and neck, the literal translation of carotid being "the artery of sleep." (Karoo—I sleep). Another early theory depended upon the observation mentioned above that sleep and activity seemed to bear a direct relationship. It was, therefore, postulated that the breakdown products of muscle metabolism which would occur in maximum quantities when the subject was fatigued had a direct action upon the brain causing sleep. A moment's reflection, however, shows us that such a supposition is untenable. Fatigue and sleep are by no means synonymous. People sleep frequently in the absence of any fatigue, either mental or physical, and on the other hand we all know from personal experience the unpleasant sensation of being overtired and unable to sleep.

Brown-Sequard was probably the first to recognise the importance of "*inhibition*" in the mechanism of sleep production and just over twenty years ago Pavlov (1927) brought forward some strong evidence to show that cortical inhibition did indeed cause somnolence. He showed that if a conditioned reflex was produced in a dog by the sounding of a bell before it was given food, and that then the bell was constantly rung but no food was forthcoming, the dog would soon lose all interest in the sound of the bell and if it continued the animal would unfailingly go to sleep. He therefore considered that inhibition of the conditioned reflex occurred in the cortex and that this inhibition subsequently spread to affect all cortical activity and so sleep resulted.

Kleitman (1929) also believed that cortical inhibition was the all important factor in sleep production but he considered that this was brought about, not by a subconscious suppression of cortical activity with a subsequent spread of inhibition throughout the cortex, but by a decrease in the afferent stimuli received from the sensorium.

Recently the electro-encephelogram has provided strong confirmatory evidence that cortical inhibition does indeed take place during sleep, for the tracing is identical with that seen in decerebrate animals.

The importance of cortical inhibition in the production of sleep can, therefore, scarcely be doubted, but the problem is a complex one for much evidence is available in support of what must at first sight appear to be an alternative theory, namely, that there exists in the mid-brain a sleep centre. The belief that such a centre exists was

first put forward by Dubois (1896) over half a century ago, for he demonstrated that disturbances of sleep resulted from the occurrence of lesions situated near the floor of the third ventricle and near the anterior part of the aqueduct of Sylvius. Several more recent pieces of work have confirmed these findings of Dubois. Demole (1927) showed that the injection of calcium chloride into the floor of the third ventricle produced sleep while a similar injection of potassium chloride had an exactly opposite effect. He noted the interesting fact that the level of the blood calcium falls during sleep and attributed this fall to the fact that the calcium had been concentrated in the brain where its action upon the " sleep centre " had produced somnolence.

Hess (1932) produced sleep in animals by injecting ergotamine into the third ventricle and considered that this was due to an upset in the parasympathetic-sympathetic balance brought about by the stimulation of the parasympathetic via the hypothalamus. The exact way in which this operation was brought about remained obscure.

More recently Ranson (1939), by producing bilateral lesions in the hypothalamus in monkeys, caused the animals to fall into a deep sleep.

Furthermore, the available evidence derived from human autopsy material certainly supports the view that a sleep centre must exist in the hypothalamic area in man, for von Economo (1928) showed that in cases of encephalitis lethargica where sleep was a prominent symptom, the predilection of the virus for the grey matter around the anterior end of the hypothalamus was a constant feature, and intracranial tumours are most likely to produce sleep when they are situated in the interpeduncular space.

From a consideration of the evidence already stated therefore, it would seem that any satisfactory theory which sets out to explain the physiological basis of sleep production must embrace both the presence of a sleep centre situated in or near the hypothalamus and the recognition of the importance of cortical inhibition. Adie has attempted to summarise the position by postulating that the destruction of such a sleep centre in the brain stem causes a secondary inhibition of cortical activity. It would perhaps be more accurate to describe this centre as a " waking " rather than a " sleep " centre as its destruction causes somnolence, but in the present state of our knowledge such refinements are unnecessary and Adie's thesis forms a practical basis upon which to build up a workable understanding of the problem of the various ways in which sleep or insomnia may be produced.

HYPNOTIC DRUGS.

We must now turn for a moment to the pharmacological action of the sleep producing drugs. As we might expect from the considerations mentioned above these act in two ways. They may either act directly upon the cortex and, therefore, they will be without effect upon a decerebrate animal, or they may act by depressing the hypothalamic centre and thus their action will be as marked after decerebration as in the intact animal. Many drugs act to some extent in both the above ways.

Common examples of the cortical group are potassium bromide, paraldehyde and alcohol, while those acting upon the sleep centre include chloral and hyoscine. Morphia acts in both ways and this is also true of the barbiturates, which, however, in the doses usually employed act chiefly on the cortex.

TYPES OF INSOMNIA.

We are now in a position to turn to the clinical application of our problem and to consider the various ways in which insomnia may be brought about. While it is realised that by dividing such a complex subject as insomnia into watertight compartments we may, with some justification, be accused of over-simplification of the problem, it would appear that the recognition of definite clinical types of the condition has much to recommend it from a practical and clinical standpoint. I shall describe, therefore, six specific types of insomnia as clinical entities and discuss the treatment of each. These six types may be enumerated as follows :—

1. Primary cortical insomnia.
2. Insomnia secondary to anxiety state.
3. Insomnia secondary to pain.
4. Insomnia secondary to fear.
5. Insomnia secondary to depression.
6. Insomnia secondary to mania.

1. *Primary cortical insomnia.*

By this is meant the common type of insomnia which is unassociated with any psychopathic condition. To visualise the essential processes which bring about this

very prevalent yet distressing complaint it is pertinent to consider those individuals who present a complete contrast to patients suffering from insomnia, namely, those fortunate people who have acquired the happy knack of dropping off to sleep at will. This is brought about by the subject voluntarily suppressing all co-ordinated conscious thought and allowing the thoughts to wander at will. No ordered train of thought is followed and very soon cortical inhibition ensues and in a matter of minutes the subject is asleep. Primary cortical insomnia on the other hand is caused by the complete inability of the subject to suppress conscious trains of thought. He continues to turn the events of the previous day over in his mind, the cortical cells remain active and sleep will not come. All normal people suffer from this state of affairs from time to time but some individuals are far more prone to develop it than others. Any benefit that comes from the counting of sheep going through a stile is due to this repetitive process reducing the need for cortical activity, so that inhibition is produced. A dull book may have the same effect. A hot drink, by producing a sense of contentment and well-being may help to quieten over-active cortical thought and a similar successful result may be obtained.

As we have seen, bromides, paraldehyde and alcohol have a direct action in suppressing cortical activity, hence the value of the night cap, but the drug of choice is probably seconal, 1½–3 grains. This member of the barbiturate family has a predominantly cortical action which, with its relatively quick acting effect and its rapid excretion, make it an ideal choice for this type of insomnia. Once the patient is asleep he is unlikely to wake up so that a drug with a long continued action is unnecessary, and seconal will be completely excreted in three or four hours so that there is no fear of a hangover in the morning. In prescribing seconal it is important to tell the patient that the drug will be completely out of the system long before morning and to impress on him that there is no danger of addiction. He should be allowed to give it up in his own time and in his own way and if no pressure is brought to bear on him to discontinue its use, it is highly probable that he will give it up easily and that he will regain the normal aptitude for dropping off to sleep. Any pressure to discontinue taking it or any suggestion that it is injurious will, by causing worry, defeat the end in view and may indeed cause the drug to lose its effect. Seconal given in the ordinary way takes about forty-five minutes to act and, therefore, the patient should take it at the time he takes a hot drink preparatory to going to bed and not when the light is put out. If in certain circumstances a quicker action is desired this may be obtained by pricking the capsule when absorption will be hastened.

2. *Insomnia secondary to an anxiety state.*

This is an extreme example of the type of insomnia described above. Here cortical inhibition is impossible owing to anxiety which causes disturbing thoughts to occur over and over again. The treatment is the same as that described in primary cortical insomnia, but a larger dose of sedative may be necessary. The anxiety causing the condition should of course be removed if this is possible.

3. *Insomnia secondary to pain.*

When the cerebral cortex is under constant bombardment by pain impulses from the sensorium sleep becomes impossible. The rational method of treatment for this type of insomnia is, therefore, the removal of the cause and the drugs of choice are those which cause analgesia.

The use of aspirin and phenacetin may be dramatic and their effect may be enhanced by combining them with a small amount of codeine. This is the secret of the well-known and valuable veganin tablet or its hospital equivalent " Tab. Codeine Co," which may at times be most effective in banishing the pain of carcinoma and should always be given a trial in these patients.

For more severe and intractable cases it may be necessary to resort to morphia or heroin and this course will be most readily adopted when the pain is the symptom of an incurable condition.

For other patients pethidine (100 mg. orally or by injection, or physeptone (5–10 mg.) are worthy of trial. These preparations are less likely to cause addiction than are morphia or heroin and the depressing effect upon the respiratory centre is very much less.

It must be remembered that pain and anxiety go hand in hand and if the latter can be allayed an intolerable pain may be made much more bearable, so that a sedative may be combined with an analgesic. In this connection the well-known " three-fifteens " (potassium bromide gr. 15, chloral hydrate gr. 15, tincture of opium mm. 15)

merits especial note ; it has deserved the gratitude of many a patient and their medical attendants.

4. *Insomnia secondary to fear.*

Although in this condition the chief complaint may be insomnia, in actual practice the patient is terrified of going to sleep and is doing all he can to avoid it. The reason of his fear of sleep may be that he knows he will get terrifying dreams. This type is relatively rare in civilian practice but was all too common in battle casualties. An occasional example is provided by psychotics who suffer from depersonalisation, for they fear that if they go to sleep they will lose the few remaining links with their normal surroundings.

Explanation of the cause of the insomnia to the patient may help a great deal. Once sleep is obtained they may well enjoy a normal night's rest. On the other hand, the dreams they fear may wake them up and so, although seconal may be all that is required, some longer acting drug such as sodium amytal is usually more satisfactory. It may be advisable to combine a drug that acts on the cortex with one which acts primarily upon the sleep centre and such a mixture as potassium bromide and chloral hydrate gr. 15 a.a. may be very satisfactory. In severe cases when a short term policy is envisaged, the addition of 10 or 15 minims of tincture of opium to such a mixture will enormously enhance its effect. We have already referred to this excellent remedy in discussing the treatment of insomnia when this is due to pain.

5. *Insomnia secondary to depression.*

Typically the story of this type is different from those described above. While in the previous examples the main difficulty was experienced on retiring, here the patient will fall asleep normally only to wake after two or three hours and find himself quite unable to sleep again. He will lie in misery thinking all his depressing thoughts. Seconal in such cases would be of little value and a drug with a more prolonged action is essential. Sodium amytal is often very valuable and this may be combined with a dose of paraldehyde if tolerated. We are dealing here with a condition which will in all probability be a long term one so that addiction is a very real danger and for this reason all morphia derivatives should be avoided. Depressive patients may have a greatly increased tolerance to drugs although the converse may be true, so that the dose will have to be determined to suit each individual patient. A drug such as chloral which acts predominantly upon the sleep centre may also be of value. The condition of insomnia will clear as the depression improves and it appears to us likely that in true depressive states the sleep centre is an important factor in the production of insomnia, although cortical lack of inhibition also plays its part.

6. *Insomnia secondary to mania.*

In insomnia secondary to manic states the cortex is in a pathological state of activity, so that inhibition is impossible. The patient will state that he is fine and does not require sleep, although in point of fact he is suffering from severe mental and physical exhaustion. Such patients are resistant to all hypnotics and may be unaffected by doses of drugs which would produce deep unconsciousness in a normal subject. They are generally very averse to taking drugs and in extreme cases the parenteral route must be used. Paraldehyde 5–10 cc. intramuscularly is a valuable remedy and this may have to be repeated several times. In cases of emergency, hyoscine hydrobromide gr. 1/50 subcutaneously may be tried. This is in excess of the pharmacological dose 1/200–1/100 gr. but smaller doses of hyoscine may increase the mania and if the situation is such that the use of hyoscine is deemed essential, 1/50 gr. for an adult male should be given. This will produce deep sleep in most cases in a matter of ten to fifteen minutes. The manic state must be dealt with along psychiatric lines which do not come into the scope of the present discussion.

PATHOLOGICAL SLEEP.

We must now turn to those conditions where derangement of the normal processes by which sleep is produced causes not insomnia but an abnormal amount or type of sleep. The term " pathological sleep " is applied to all such conditions which may be subdivided into the narcoleptic group and hypersomnia. It is customary to include in the narcoleptic group four different conditions namely : narcolepsy, cataplexy, sleep paralysis and sleep hallucinations. These conditions are probably due to the sudden abnormal onset of partial or complete cortical inhibition, which as suggested by Adie may be brought about by a disturbance of the sleep centre in the brain stem. One or more types may occur in the same patient.

THE NARCOLEPTIC CONDITIONS.

In patients whose disorder comes within this group, emotion is very frequently a predisposing cause to the onset of abnormal sleep.

Narcolepsy.

In narcolepsy the patient suddenly and often for no reason falls asleep and may remain so for a matter of seconds or of hours, but it is always possible to rouse him by a stimulus which would awake him from natural sleep. Several attacks may occur in a single day.

Cataplexy.

This strange condition is in some ways similar to narcolepsy but consciousness is not lost, so that strictly it cannot be classed as a disorder of sleep. In view of its association with narcolepsy it is customary, however, to include it in this group. In a typical attack the first sign is a drooping of the eyelids which is rapidly followed by a nodding forward of the head and the patient slumps to the ground partially or completely paralysed. He is well aware of his surroundings but is quite unable to move. Twitching of the muscles may occur. The attack is of short duration. Emotion is very often the predisposing cause of such attacks and anger or laughter result in the patient falling helpless to the ground. It is considered to be due to a sudden cortical inhibition of a less widespread nature than that which gives rise to narcolepsy.

Sleep Paralysis.

Sleep paralysis (which consists of the onset of muscular paralysis while the mind is alert) may occur in association with narcolepsy or on its own. It is a most unpleasant condition which arises when the patient is either on the point of falling asleep, when it is known as predormital or hypnagogic paralysis, or in the process of waking, when the terms post-dormital or hypnopompic are applied. Hypnagogic paralysis lasts seconds or minutes and is followed by natural sleep unless anxiety about the condition causes the patient to become fully awake. Hypnopompic paralysis is especially likely to follow terrifying dreams so that here again we see the strong emotional factor at work. It appears to be caused by an uneven onset of, or recovery from, cortical inhibition so that the part of the cortex controlling muscular movements is asleep while that controlling consciousness is uninhibited. In minor degrees it is not at all uncommon following nightmares, and can hardly be looked upon as a pathological condition.

Sleep Hallucinations.

Sleep hallucinations are terrifying experiences generally of a visual nature which have been described as midway between dreaming and true hallucinosis. The patient has no insight into the condition at the time although this returns later. As in the case of sleep paralysis, these hallucinations may be hypnagogic or hypnopompic and the former are seldom, the latter frequently, associated with true narcolepsy.

The narcoleptic group of conditions described above are considered to be due to a disturbance in the sleep centre which results in sudden cortical inhibition of a partial or complete nature. Such a disturbance may be associated with an organic lesion although in the majority of patients, and especially when it occurs in young male adults, no such lesion is found. There appears to be some connection with epilepsy as a family history of this condition is not infrequently obtained in the idiopathic group. Organic lesions which must be considered are cerebral tumour affecting the brain stem, encephalitis, arteriosclerosis and trauma. There also appears to be an association with endocrine obesity as narcoleptic phenomena are especially liable to occur in such patients. The symptomatic treatment for narcolepsy and cataplexy is the administration of amphetamine sulphate in doses of 10 mg. twice or three times daily and such treatment may have the most satisfactory results.

HYPERSOMNIA.

It now remains to consider briefly the remaining type of pathological sleep, namely, hypersomnia. This is a condition of pathologically prolonged and deep sleep but the electroencephalogram shows that it is a true sleep and not a coma. The patient spends most of the day and night in a deep slumber from which he can only be aroused with difficulty. This condition is far more likely to be secondary to an organic change than is the case in the narcoleptic group and in addition to the organic causes considered in this connection, namely, cerebral tumour, encephalitis, arteriosclerosis and trauma, the possibility of syphilis, trypanosomiasis or sleeping sickness, diabetes, uræmia or an overdose of drugs must be kept in mind. Amphetamine may improve the patient symptomatically but in view of the probable organic basis of the condition it is less

likely to have the beneficial effect which may be expected when it is administered to patients suffering from narcolepsy.

CONCLUSION.

In conclusion it must be stated that the subject of this discussion is not one that lends itself easily to classification and each patient must be studied as an individual. In finding the most satisfactory treatment for his insomnia one must often resort to the well recognised method of trial and error. Nevertheless, the study of sleep (or the lack of it) is a subject which will repay some serious consideration and the successful treatment of insomnia, an all too common symptom, will add greatly to the comfort and well being of the patient and earn for the doctor a debt of sincere gratitude.

(I wish to thank Dr. W. N. Mann and Dr. D. Stafford-Clark for their helpful criticism and advice during the preparation of this article.)

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Reviews

Hale-White's Materia Medica. By A. H. DOUTHWAITE. 28th Edn. Churchill. *Price* 16*s.*

This book seems almost too well known for comment. It must have been reviewed many times on the publication of its various revisions.

The present edition, however, has special significance for two reasons: first, it coincides with the death of its distinguished author, Sir William Hale-White, K.B.E., M.D., early this year and, in the second place, it synchronises with the appearance of the British Pharmacopæia of 1948, the first complete issue after a lapse of sixteen years. All the additions, deletions and many alterations in the latter have been included by Dr. A. H. Douthwaite in this present work—the latest of his many excellent editions.

D.M.C.

Introduction to Diseases of the Chest. By J. MAXWELL. 3rd Edn. Hodder & Stoughton. *Price* 12*s.* 6*d.*

The chief value of this book is the clear and simple manner in which it introduces the student to the study of pulmonary disease. The earlier chapters on history-taking and the physical examination of the chest are particularly valuable, as they are written in a clear and concise style, and the subject-matter is quite reliable. A fuller account of the anatomy of the bronchial tree would have been helpful.

At the end of the book are a series of clear and well-produced X-ray plates of all the common chest lesions.

K.E.

Clinical Endocrinology and Constitutional Medicine. By A. P. CAWADIAS. Frederick Muller. *Price* 42*s.*

This book sets out with the admirable idea of describing endocrinology from the physiological standpoint. Thus, before any clinical syndrome is outlined or any disease described, the physiology of the condition is fully entered into. The value of this approach, however, is almost entirely negatived by the truly appalling conglomeration of technical phrases and composite words. Thus a footnote on page 14 states "this is written from a biological, thus phænomenological, point of view. It does not interfere with a noumenal spiritual interpretation of the Universe." Statements of this kind may clarify the text for the experts, but for the ordinary reader they merely confuse the issue.

The author holds that the subject of endocrinology is one for the specialist. This is debatable, but that this book is for the specialist, and not for the casual reader, is indisputable.

K.E.

MASS RADIOGRAPHY.

All credit to those responsible for the vast amount of work involved in the organisation and management of the mass-radiography unit. The whole business has been conducted most efficiently. Only a very few of those people for whom appointments were made have failed to attend at the appropriate times. The actual examination has taken but a few minutes in each case—with no waiting at all beforehand.

The Nuffield Statue

The statue of Viscount Nuffield in the West Quadrangle of Guy's House is to be unveiled on the afternoon of Wednesday, June 29th, at 3 p.m., by Lord Goschen, a former Treasurer and President of the Hospital.

Opportunity is being taken to invite a number of guests to view the Hospital and Medical School on that afternoon. In addition to official guests, it is proposed to ask representative groups of Medical Students, Nursing Staff, Physiotherapy and Radiography Staff and Students, Administrative Staff, Kitchen and Domestic Staff, Works Department Staff, Porters, etc., to invite friends. Invitations will be issued in due course.

The Out-Patient Department, Physiotherapy Department and Dental School will be closed, and all wards and departments will be open for inspection.

The Band of the Irish Guards will play in the grounds during the afternoon and tea will be provided for the guests.

Academic dress or ordinary dress will be worn.

The Steele Diaries—VI

PATIENTS—(*continued*)

23rd July, 1873.

I have to report another death from Chloroform which occurred in the operating theatre last Friday, shortly after Mr. Durham had performed tracheotomy on the patient. A post-mortem examination afterwards made on the patient showed her to be suffering from tubercular disease of the lungs.

27th August, 1873.

On Saturday last another fatal case from Chloroform inhalation occurred and on this occasion in the Clinical Ward. At the desire of the relatives of the deceased an inquest was held yesterday and the jury returned a verdict of death from chloroform properly administered.

22nd October, 1873.

The general use of the Carbolic Acid spray producers in the Surgical Wards renders it necessary that there should be an apparatus in each of these wards. There are now seven of these instruments in use in the wards and it would be desirable to have a few more in stock as there is considerable difficulty in obtaining them in the first instance.

14th January, 1874.

The number of Surgical operations registered amounted to 351 of which 73 terminated fatally. The number of operations entered is higher than the corresponding number of any year since 1867 and the mortality is a very little in excess of the average. Among the more important operations were 11 cases of Ovariotomy of which 3 recovered, Colotomy 4 of which 1 recovered, Lithotomy 7 of which 4 recovered, and 48 Amputations of limbs of which 34 recovered. There has been an unusual number of Joint Excisions, the total number amounting to 17 of which 11 have been discharged comparatively well. Among new operations reported are abdominal section for obstruction of bowel and a new method of treating aneurism by stuffing the sac with horse hair, both cases were fatal. Chloroform proved fatal in 3 cases in which it was administered in the course of the year.

14th January, 1874.

The number of women confined at their own homes through the Lying-In Charity has amounted during the year to 2,213 or 305 less than in 1872. This decrease is accounted for by the diminished area of the Charity during the greater part of the years.

Of these the	Male Children born alive were	1,142
	Female " " " "	1,006
	Stillborn Males	54
	Stillborn Females	34
	Total	2,236

Of the children 2,145 presented naturally at birth, 43 were Breech, 14 Face, Foot 13, Hand 11, Transverse 2, Placenta Praevia 8.

The Surgical operations necessary to complete labour were 34 in number, namely, 4 Perforation or Craniotomy cases, 13 cases of turning the child in uterus, and 17 cases where the long forceps were applied. The deaths among the mothers have been much higher than in former years, numbering altogether 16 cases. Of these 5 were due to puerperal blood poisoning, 4 to Peritonitis, 2 to Pneumonia, 2 to Hæmorrhage after delivery, 1 to Phthisis, 1 Convulsions, and 1 attributed to exhaustion.

Correspondence

Signal Lights.

SIR,—The success of a signalling system such as we now have depends on the ability of those who are on call to see the lights.

Although, in general, the new lights are a great improvement on what we had until recently, some changes are still necessary if we are to rely upon them.

I would suggest, therefore, that lights be installed in the following places where those on call may wish to go : the Post-mortem Room, the Lower Spit, Salomon's Centre, Gynæcological Out-patients, the Anatomy Theatre, the Wills Library and in Hunt's House, so that they may be seen from the Park.

The Library presents a problem, but the lights could be placed so that they were seen from two tables only. Those on call could easily sit by them. In the Anatomy Theatre the lights could be encased so as to be visible only to those sitting on the back row. So placed they need not disturb others in the theatre.

As for Hunt's House, lights installed on the first floor landing would be useful not only to those inside but also to those in the Park.

There may be other situations in which these signals are needed, but I think that I have mentioned those most urgently needed.

Yours, etc.,

G. ST. JOHN PENNEY.

Guy's Hospital, S.E.1.

Case Presentation.

SIR,—The poor exhibition by ward clerks and dressers of which you complain in Passim is certainly a matter for concern. I believe that the true reason lies more deeply than you suggest. It is not just a question of inability to "stand up, speak up and shut up." The ability to do these things, like the ability to present a case well, derives partly from intelligence and partly from independence of mind. Our intelligence is probably a fixed quality. Not so our independence of mind. This latter is a quality which can be developed. It is one of the highest functions of education to develop it. But to what extent the present teaching at Guy's does so is open to question. In some cases it certainly does so. My impression is that they do not form the majority. You quote a tutor at Guy's whose methods were martial. I quote you a tutor whose methods are the very reverse—a man who pays his firm the compliment of not only expecting its individuals to present their case histories clearly but also to give definite and accurate physical signs, to give a diagnosis and to give a prognosis.

This, I believe, is the way to foster independence of thought. I believe it is a way superior to the bedside discourses of which case presentation often forms only a short preliminary, and I believe that, were the emphasis more on this sort of clinical teaching, there would be fewer displays by ward clerks and dressers of the sort which you so rightly lament.

Yours, etc.,

"DRESSER."

Guy's Hospital, S.E.1.

What is the Meaning of This?

SIR,—The mural painting in the new Common Room is an excellent decoration for a modern canteen but not for a Common Room.

There are two ways of decorating a Common Room. The conservative method is to hang paintings and etchings of some of the great men who have worked at this hospital. The radical method makes use of landscape and still-life paintings by contemporary artists.

The latter relies on the tastes of a selection committee and is therefore too risky. The former gives us a stimulating reminder of Keats, Bright, Addison, Astley Cooper and others who deserve to be remembered.

Yours, etc.,

A.H.R.H-C.

Guy's Hospital, S.E.1.

The Catering Company.

SIR,—From time to time there has been correspondence in the *Gazette* with criticism of the Catering Company, some of it justified, some of it justifiable, and some of it due to lack of understanding of the catering set-up. There is, I am informed, a firm impression that persons unknown are making a good thing out of the catering and that these sinister unknowns, presumably the Directors and Shareholders, are earnestly engaged in grinding the faces of the poor students and depriving them of the abundance which is their due.

Actually the Catering Company suffered a loss of thousands of pounds in the year past and only escaped bankruptcy through help given by the School.

The Directors consist of a few members of the Staff, Representatives of the Students' Club, the Clubs' Union, the Residents and the Superintendent and the Dean. They are all unpaid. The Shareholders are a generous body of men and women, mostly Guy's Staff and their relatives, who put up the money to finance the Company in 1927 when Guy's first decided to run its own catering business instead of farming it out to contractors. The large sum of about £30 has been distributed amongst them annually, except last year when no dividend was paid. During the twenty odd years the Company has been in existence nearly £5,000 has been paid back to the Guy's community through the Clubs' Union, the Students' Union and in other ways.

The heavy financial loss incurred in 1948 was largely due to the great increase in wages and the price of food and services, which was not offset by a corresponding increase in prices or economy in other directions.

The Catering Company has never tried to do more than maintain an adequate favourable balance and this was easy enough in normal times, but it became obvious that the organisation of the Company was not adequate for the difficult times through which every catering business is at present passing.

In March this year the Board of the Company decided to call in expert catering advisors and accordingly, Messrs. John Gardner (London), Ltd., were asked to carry out an investigation and report to the Board. Their report, largely the work of Miss Blundell, the firm's energetic troubleshooter, was recently accepted by the Board and reorganisation in all departments has started and it is expected that the results will be apparent during the coming months in the form of better food and better service. Messrs. Gardner hope that it will not be necessary to increase the overall prices and the Board shares their hope, while noting with apprehension the upward trend in prices everywhere else.

I append the names of the present Board. Please don't shoot them ; they are doing their best. The Board is prepared to receive suggestions for improvement at any time by letter to the Secretary of the Catering Company, Mr. J. H. E. Winston, or through the Students' Club or Clubs' Union or Staff representatives.

Names of Directors.

Professor T. B. Johnston
Mr. R. Davies-Colley
Mr. W. M. Mollison
Mr. W. D. Doherty
Mr. S. H. Wass
Mr. D. G. Chalmers
Mr. J. C. Walby
Dr. T. M. L. Price
The President of the Residents
Dr. E. R. Boland (Chairman)

Yours, etc.,

Guy's Hospital, S.E.1. E. R. BOLAND.

Residents' Riot.

SIR,—We could not be other than disgusted at the abominable condition of the "Spit" following the Residents' Farewell Dinner. Chairs and flower-pots had been broken, the newly-painted walls bespattered with sauce, and the skylight smashed in several places, so much so that the domestic staff were naturally reluctant to clear up the mess.

Such childish, irresponsible behaviour sets an appalling example to students and hardly becomes members of the Staff of Guy's Hospital. If this vandalism is necessary, may it be confined in future to quarters other than those in everyday use by members of the Hospital ?

Yours, etc.,

Guy's Hospital, S.E.1 " SEVERAL SENIOR STUDENTS."

House Appointments

JUNE 1st, 1949

ASSISTANT HOUSE SURGEONS.

To	Sir Heneage Ogilvie and Mr. Blackburn	Mr. I. E. Evans
	Mr. Massie and Mr. Wass	Mr. T. B. Brewin
	Mr. Eckhoff and Mr. Lawrie	Mr. A. J. Salmon
	Mr. Atkins and Mr. Glover	Mr. G. W. Scott
	Mr. Slesinger	Mr. B. G. B. Christie

OUT-PATIENT OFFICERS.

Mr. N. H. Porter — Mr. J. D. Williams
Mr. R. D. Allen — Mr. P. Chadwick

HOUSE SURGEONS.

To	Sir Heneage Ogilvie and Mr. Blackburn	Mr. C. H. Talbot
	Mr. Massie and Mr. Wass	Mr. R. Merryweather*
	Mr. Eckhoff and Mr. Lawrie	Mr. J. Vance
	Mr. Atkins and Mr. Glover	Mr. C. R. Neve*

HOUSE PHYSICIANS.

To Sir John Conybeare and Dr. Hardwick	Mr. E. W. Graham Mr. M. Hatton
Dr. Boland and Dr. Baker	Mr. A. A. Craigen Mr. E. F. Soothill
Dr. Hampson and Dr. Kauntze	Mr. D. C. Deuchar Mr. T. E. Jeffreys
Dr. Douthwaite and Mr. Mann	Mr. T. R. L. Finnegan* Mr. D. F. V. Brunsdon*

RESIDENT OBSTETRICIANS.

1.4.49—30.6.49	Mr. R. D. C. Hart
1.5.49—31.10.49	Mr. H. W. Trusted*
1.6.49—31.8.49	Mr. J. A. Bulleid*
1.7.49—31.12.49	Mr. A. W. Banks*

NEUROLOGICAL H.P.
Mr. K. M. Citron

CHILDREN'S H.P.
Mr. E. G. Cook*
Mr. K. A. A. Campbell*

DERMATOLOGICAL H.P.
Mr. J. K. Morgan*

GENITO-URINARY H.S.
Mr. R. G. Nicholson (3 months)

OPHTHALMIC H.S.
Mr. H. L. Backhouse* (6 months)

H.S. TO THORACIC UNIT.
Mr. K. M. S. Hume (3 months)

THROAT AND EAR HOUSE SURGEON.

Mr. R. W. Glenn (3 months)

ORPINGTON	Ear, Nose and Throat House Surgeon	Mr. J. B. F. Boyle
	Orthopædic House Surgeons	Mr. A. C. M. Mann Mr. A. T. T. Forrester
PEMBURY	House Surgeons	Mr. J. H. Evans Mr. F. G. Ellis
JOYCE GREEN	House Surgeon	Mr. J. G. Brice

* Ex-Service.

Guy's Diary

JUNE

ACADEMIC AND SOCIAL

Exhibition. Surgical Dept. "Rectal Bleeding."

6th. 12.00. Surgical Staff Conference. Clinical Theatre.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

7th. 10.00. Opening of Art show. Gordon Museum.
12.00. Neurological Demonstration. Preclinical Classroom.

9th. 4.30. X-ray Meeting. Gordon Museum.

10th. 1.00. Mr. Brock. Clinical Lecture. "Mediastinal Tumours."
2.15. Medical Dept. Combined Round. Preclinical Classroom.

11th. 10.00. Dr. Mark Ravitch (John Hopkins Hospital). Surgical Departmental Round. Clinical Theatre.

13th. 1.00. Dr. Helliwell. Clinical Lecture. "Anæsthesia for Emergency Operations."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

14th. 12.00. Mr. J. W. Mansie. Dental Clinical Lecture. "The Mechanics of the Removal of Teeth." Dental Theatre.
1.00. Dr. Bishop. Clinical Lecture. "Addison's Disease."

16th. 1.00. Mr. Massie. Clinical Lecture. "Injuries to the Elbow."
4.30. X-ray Meeting. Gordon Museum.

17th. 2.15. Medical Dept. Clinico-pathological Conference. Pathology Lecture Theatre.
4.30. Mr. Adrian Hill. "Art and the Invalid." Physiology Theatre.

20th. 1.00. Dr. Mark Ravitch. Clinical Lecture. "Surgery of the Lungs and Thoracic Parietes in Children."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

U.S.A.—ANOTHER EXCHANGE SCHEME

Arrangements have been concluded between the Students' Union at Guy's and the American Association of Hospital Interns for another Exchange Scheme, this time for students. Messrs. B. H. Bass and I. B. Thomas have been selected to attend a three months' course at Yale. They will leave England shortly on the *Queen Elizabeth*. Later in the year two Yale students will spend a similar time at Guy's.

The Residents' Ball

As good a Residents' Ball as we can remember was held at The Park Lane Hotel on Friday, 20th May, and was immensely enjoyed by four hundred and eighty people.

Mrs. Doherty very kindly received the guests, and straightaway there was a most evident atmosphere of enjoyment. The band was good. The food was excellent. The company was what one has been led to expect, Guy's men, young and old, and their ladies, old and new, all very glad to see one another.

Half-way through the evening a troupe of dancing girls, scantily clad, danced and pranced for us, whereafter, to everyone's great amusement, a small body of Residents, dressed as bathing-belles, provided the final chorus.

As the evening passed, all too quickly, one could not help thinking what an excellent institution it was that brought old friends together in such good humour once a year. The President and the Residents, and Mr. Hatton in particular, are to be congratulated on the excellence of their 1949 dance.

Sport

CRICKET

Guy's *v.* Ealing Dean

At H.O.P. Result—Match drawn.

Saturday, April 30th, 1949.

Ealing Dean 153—7 dec. ; Guy's 145—4.

P. S. Russell lost the toss and Ealing Dean chose to bat. Steady bowling, especially by Russell, kept the runs down, though Lipington did concede two sixes off consecutive balls in his second over. They declared just after five, leaving Guy's to score at 70 an hour.

Blake and Russell opened and put on 68 for the first wicket before Blake was caught. Russell went on to make 55, but the runs were beginning to come too slowly and 20 were needed from the last two overs. Nine were scored in the first of them, but the last only produced some very hurried singles.

Guy's *v.* Beddington

May 1st, 1949.

At Beddington. Result—Lost by 4 wickets.
Guy's 159—10 ; Beddington 162—6.

Beddington chose to put Guy's in first on a slow, soft wicket. Blake and Russell opened confidently and put 42 on the board before Blake was bowled. Russell soon followed him, and the runs became harder to get against very brisk fielding. Nicholson, batting No. 9, made more use of the boundary, and the score was given a last minute fillip.

The Beddington opening pair scored steadily until Russell found the stumps, after some very steady bowling, with the score at 42. But by taking every available run Beddington kept pace with the clock, and a boundary four in the last over removed any lingering hopes.

Guy's *v.* Wanderers

May 4th, 1949.

At H.O.P. Result—Lost.

Guy's 200—9 dec. ; Wanderers 201—1.

Russell elected to bat, after winning the toss, on a firm fast wicket. Blake opened aggressively with two fours and a three off the first three balls, but the bowlers settled down and had to be treated with more respect. With four wickets down for 46, Woodford came in and made his end unassailable. With the aid of the remaining batsmen he carried his score to 78 before the innings was declared.

The Wanderers were left to score at 85 an hour, but they pushed the score along with seeming ease and at an ever-increasing rate, so much so that they had twenty minutes still in hand when the Guy's total was passed.

2nd XI. Results

Guy's *v.* Honor Oak

May 7th, 1949.

Result—Lost.

Honor Oak 79—10 ; Guy's 23—10.

Guy's *v.* Ewart C.C.

May 14th, 1949.

Result—Won.

Guy's 177—7 dec. (Gee 43, Anderson 38).
Ewart C.C. 124—10 (Hodson 6—46).

BOXING

The United Hospitals' Championship held on Tuesday, 31st May, 1949, was won by Guy's with 23 points. The London were runners-up with 12 points, followed by St. Mary's with 11 points.

RUGGER BALL

Friday, 8th July, 1949

Will be held at Victoria Hall, Bloomsbury Square, W.C.2. (7.30 p.m. to 1 a.m.). Tickets 21*s.* double.

A limited number only may be obtained from The Rugger Secretary (W. P. N. Moore), Guy's Hospital, London, S.E.1.

Hospital Information, etc.

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the following appointments to the Junior Staff, appointments to date from 1st October, 1949, except where otherwise stated.

Assistant to the Director (Senior) of the Department of Surgery
Assistant to the Director of the Department of Anæsthetics
Assistant to the Director of the Department of Obstetrics
Assistant to the Director of the Student Health Service
Casualty Surgeon
Tutor in charge of the Preliminary Clinical Period Class
Medical Registrar (4)
Surgical Registrar (3)
Anæsthetic Registrar
Obstetric and Gynæcological Registrar
Registrar (P/T) Ophthalmological Department (4)
Registrar (W/T) Dermatological Department (to start as soon as possible)
Registrar (W/T) Department of Diagnostic Radiology
Registrar (W/T) Neurological Department
Registrar (W/T) Orthopædic Department
Registrar (P/T) Orthopædic Department
Registrar (P/T) Cardiac Department
Registrar (P/T) B.M.R. and Endocrine Department
Registrar (W/T) Genito-Urinary Department
Registrar (W/T) Physiotherapy Department
Registrar (P/T) Physiotherapy Department
Registrar (W/T) Pædiatric Department
Registrar (P/T) Ear, Nose and Throat Department (2)
Registrar to the Hæmatological Department
Registrar (W/T) Evelina Hospital
Registrar (P/T) Ear, Nose and Throat Department, Evelina Hospital

V.D. Department
Assistant Director
Medical Officer (Male)
Medical Officer (Female) (2)

Department of Clinical Pathology
Chief Assistant
Assistant Clinical Pathologists (3)

Department of Chemical Pathology
Assistant Lecturer (2)
Demonstrator

Department of Morbid Anatomy and Histology
Assistant Lecturer (Gull Student)
Demonstrator (2)

Anatomy Department
Assistant Lecturer
Demonstrator (W/T)
Demonstrator (P/T) (3)

Biology Department
Assistant Lecturer

Chemistry Department
Assistant Lecturer (3)
Demonstrator

Physics Department
Assistant Lecturer (W/T)
Assistant Lecturer (P/T)
Demonstrator

Physiology Department
Demonstrator

Forms of application are obtainable from the Medical School Office and should be lodged with the Dean *not later than 22nd June*, 1949.

APPOINTMENT VACANT

GUY'S HOSPITAL

Applications are invited for the post of **Assistant in the Department of Diagnostic Radiology.** Appointment for two years in the first instance. Duties to commence on October 1st, 1949. Salary at the rate of £1,000 per annum, to be adjusted when the new Ministry of Health scales come into force. Applications, accompanied by the names of three referees, should be sent to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than June 27th, 1949.

THIRD ADDISON LECTURE

This will be delivered in the Physiology Theatre on Thursday, 23rd June, 1949, at 5 p.m., by Sir Henry Dale, O.M., G.B.E., F.R.S., M.A., M.D., F.R.C.P., on "Thomas Addison—Pioneer of Endocrinology."

Chairman: Sir Herbert Eason, C.B., G.M.G., M.D., M.S., F.R.C.S.

Applications for tickets should be made to the Dean, Guy's Hospital Medical School, S.E.1, by Thursday, 16th June.

CHANGE OF ADDRESS

G. W. Garland, M.B., B.S., 65, St. Charles Square, W.10. (Tel.: LADbroke 4247.).

BIRTHS

ALLEN.—On May 23rd, 1949, at Guy's Hospital, to Judy (née Collins), wife of R. A. Allen—a son (Richard Nicholas).

MORGAN.—On May 10th, 1949, to Verity (née Eminson), wife of T. K. Morgan, M.B., B.S.—a son (Anthony John).

SUSKIN.—On November 13th, 1949, in Johannesburg, to Audrey (née Harris), wife of Michael Suskin, L.D.S., R.C.S.—a son (Lawrence Harvey), a brother for Sandra.

MARRIAGES

BUTLER—BROOKS.—On Thursday, May 19th, 1949, at Spalding, Sam Butler, M.R.C.S., L.R.C.P., of Transvaal, to Elizabeth Brooks, S.R.N., of Spalding.

GARLAND—PARSONS.—On May 21st, 1949, at St. Katharine's Church, Irchester, Northants, Gordon W. Garland, M.B., B.S., to Kathleen (Bunty) Parsons.

DEATHS

FAGGE.—On March 26th, 1949, Robert Hilton Fagge, J.P., M.R.C.S., L.R.C.P., of Melton Mowbray, Leicester.

FRENCH.—On March 5th, 1949, Ronald E. French, M.D., of Ranmore, Burgh Heath, Surrey.

RICHARDS.—On April 18th, 1949, Owen W. Richards, C.M.G., D.S.O., D.M., M.Ch., of Downes, Monkleigh, Bideford, late Director of The Egyptian Government School of Medicine in Cairo.

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G.H.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

IN the centre page of the Christmas number of the *Gazette*, we published a photograph of the large picture, painted by G. Earle Wickham, which hangs in the new Smoking Room of the College. Duly advised, we added the comment that there was hope that this room would be ready early in the New Year. Judging from the discussion, argument and debate which then raged on the merits or otherwise of this particular picture, from the comments of approval and disapproval, one might be led to assume that this ante-room was in fact opened as predicted. This, however, was not the case, and for reasons, chiefly associated with difficulties of upholstery and furnishing, only last week did the room become open for general use, for the first time.

The room in question will be remembered from the pre-war days, providing as it did, a meeting place, a reading room, a smoking room and an informal queuing centre for the restaurant and the " Spit." In those days it opened by one door onto the staircase which led from the Residents' Room up to the Restaurant, and by another on the far side, into the College proper. The far door has been filled in, and it is along this wall that the picture we have published, mentioned above, and about which so much controversy has taken place, hangs. It covers the major part of that wall, and if we feel that to be fashionable we must criticise it, then our criticism would be solely that it would look even better as a mural than hung as a picture.

Facing this, to the right of the door on entering, are two small alcoves, side by side. Into these have been fitted twin paintings by the same artist, exactly filling the recesses down to the level of the chair-backs. They look extremely well, and painted by the same hand in the same style, with the colonnade arches in the foreground, match excellently the larger picture which they face.

The trouble taken has not, however, ended here. The fireplace, which backs the wall whose windows overlook the derelict rubble behind the College, has, too, been designed by Wickham, and carries on the idea suggested by the arches of the colonnade. Even the curtains, full length and of fine material have at their heads a pelmet, in the centre of which is the same corner stone. (For various reasons we are unable to publish photographs of the two new pictures and the fireplace in this issue, but we hope to have suitable paper for them in a month's time).

The entire floor is carpeted, richly, and there is a sufficiency of armchairs and settees in green leather to seat between forty and fifty people, with comfort. In the middle of the room is a long table, and there are countless ash trays to save the carpets. The lighting is good, and besides radiators, the room should be kept warm enough in winter by the large and not unsightly gas fire.

We have probably failed to present a clear picture of this new Guy's luxury to old Guy's men, but we hope they may gather from it some idea of the very large step which has been taken to further the comfort of the present generation. We admire the spirit which decided that this job should be done well, and we admire the minds and hands which have done it well. A very great deal of trouble and expense have clearly gone into the making of this common-room and we do most devoutly hope that however good and however boisterous the parties which the college sees in the coming years may be, those same good boisterous fellows will keep their hands and missiles off this communal possession.

THE next Annual Dental Society Ball will be held at Grosvenor House, Park Lane, on Friday, 18th November, 1949, from 8 to 1 o'clock.

The Role of Radiotherapy in the Treatment of Malignant Disease.

A Lecture delivered in the Medical School at Guy's Hospital on Monday, May 16th, 1949,

by A. B. WAYTE, M.B., D.M.R.E.

LADIES AND GENTLEMEN,—In the time at my disposal it will not be possible to give you more than an outline drawing of the role that radiotherapy may play in the treatment of malignant disease. As in most outline drawings, the lines will have to be a little hard and firm and will allow none of the fine shading which exists in any branch of medicine. For this reason, you must realise that a statement that a particular tumour is suitable for treatment by radiotherapy, does not mean that it is the only method of treatment or necessarily the best method in any particular case. Other factors must always be considered, and the choice of the method of treatment in each case should be made only after all the facts have been carefully considered.

Among other factors the availability of good radiotherapy is important. It is only in well equipped and adequately staffed centres that the complicated and time consuming techniques of modern radiotherapy can be carried out in an efficient and safe manner. It is probably true to say that unwise or even frankly bad surgery is preferable to bad radiotherapy and may well cause less suffering to the patient.

Therefore, in this lecture it should be assumed that the radiotherapy available is to be of a high standard, and can be given without delay, since in practically all cases of cancer, delay, of even a few days may mean the difference between success or failure.

Before considering the part to be played by radiotherapy we must take the problem of cancer as a whole.

In England about one death in seven is due to cancer. Miss Margaret Todd has recently published the results of an enquiry into the extent to which cancer patients in Great Britain are treated by radiotherapy. This report has been very carefully prepared from data supplied by the London teaching Hospitals, the major radiotherapy centres throughout the country and the statistical returns of hospitals approved by the Radium commission. It is a valuable survey and it gives some indication of the number of cancer patients that require treatment by radiotherapy.

About 86,000 new cases of cancer occur annually in Great Britain and in 1946, 30,000 new patients were treated by radiotherapy at the major radiotherapy centres alone. Therefore, it can be stated that about 40 per cent. of patients suffering from cancer will require radiotherapy as part of their treatment.

If we consider the particular area for which Guy's, together with King's and other Hospitals, is responsible, there is a population of about 2,945,000.

This population can be expected to produce about 6,184 new cases of cancer a year and of these about 2,474 will require radiotherapy. If this hospital is to play her part in dealing with this problem something like 1,000 new cases annually will require treatment.

The action of radiotherapy requires some explanation.

Briefly, radiotherapy derives its usefulness from the fact that some, unfortunately by no means all, malignant cells are more easily destroyed by its action than the cells of normal tissues. In other words cells show a differential response to its action and its affect is not that of cautery. Unfortunately the dose level required to destroy a tumour is, in many cases, not very much different from that which will destroy healthy tissue. Consequently, one is always working at the upper limits which normal tissues will stand and it is for this reason that such careful measurements of dosage, and rather elaborate techniques of treatment are needed.

Firstly, let us consider normal tissues. The amount of radiation which normal tissues are capable of tolerating depends mainly on three factors.

(1) The nature of the tissue.

(2) The volume of tissue irradiated.

(3) The blood supply.

Some tissues of the body are much more sensitive to radiation than others, for instance, lymphoid tissue is much more easily destroyed than nervous tissue. The volume of tissue which is irradiated is extremely important. Small volumes of tissue can be taken up to a very much higher dose than large volumes. A tissue with a good healthy blood supply will tolerate a higher dosage than one with a poor blood supply. Old patients with senile atrophic tissues will stand less irradiation than young and healthy adults. Patients with arterio-sclerosis or syphilis will again tolerate less and, most important, tissues which have had their blood supply interfered with by an operation will not tolerate as high a dosage as normal tissues. How does this affect the treatment of a patient? Clearly if the growth is a small one, in healthy tissue, with a good blood supply, such as the tongue or lip, it will be possible to give a dosage high enough to be curative without undue risk. On the other hand if the growth is large, or even moderately large, it will not be possible to give a dose that is likely to be curative unless the growth is particularly sensitive to radiation.

Therefore, it is fair to say that radiotherapy has very marked limitations so far as curative procedures are concerned, and for this reason patients can be divided into those suitable for radical treatment, and those suitable for palliative treatment, in which the aim is to make patients more comfortable and possibly prolong their life.

Radical radiotherapy is only technically possible if the growth is small or else is markedly sensitive to irradiation. Unfortunately the factors which reduce the safe dosage level in normal tissue do not also reduce the lethal dosage level for malignant cells. In other words a growth of large size with a poor blood supply requires just as high a dosage to destroy it as a small growth with a good blood supply.

Radical radiotherapy is an ordeal for the patient and is quite as severe a procedure as a major surgical operation. It causes considerable discomfort both during treatment and for a month or six weeks after treatment, until the reaction has healed. In addition there is some risk of destroying normal tissue permanently and causing necrosis. This risk should be small if the treatment is carefully planned and carried out, but it is always present and must be accepted in the same way as an operative mortality.

From what has been said you will realise that cases for radical radiotherapy must be selected with care and treatment reserved for those cases in which there is a reasonable chance of permanent cure. If no such chance exists it is unjustifiable to submit a patient to radical radiotherapy and a palliative technique should be used.

Palliative therapy, on the other hand, is a much less trying ordeal for the patient and should cause no great discomfort nor should there be any danger of necrosis. In selecting patients for palliative radiation great care must be taken to ensure that the ultimate fate of the patient is made no worse by the attempts at palliation. It is useless and not humane to prolong life, if by doing so one is simply increasing the period of suffering and making the patients ultimate fate worse than it would have been if untreated.

We are now in a position to consider the types of growth which may benefit from radiotherapy, but it must be remembered that a mere list of tumours is not enough. Each patient must be considered individually. It often happens that a case may be, according to the list, suitable for radiotherapy as the main line of attack; but on examining the patient and taking all the factors into consideraton, surgery may be more suitable in that particular patient. For this reason the closest possible co-operation between all those interested in malignant disease is essential if results are to be improved.

For classification tumours can be divided into five groups, and each group will be considered in turn.

Ia.—*Radiotherapy the Treatment of Choice.*

Seminoma.	Lymphosarcoma.	Lymphadenoma.	Neuroblastoma.
Wilm's tumour.	Reticulosarcoma.	Reticulo-endothelial growths.	
Embryonal tumour of ovary.	Thymoma.		
	Endothelioma.		
	Ewing's tumour.		

Radiotherapy is given as the treatment of choice in this group becaue they are very sensitive to radiotherapy and are usually so widespread that surgery is powerless. On the whole, although they are very sensitive to radiotherapy, they are not by any means easily curable and the cure rate in these tumours is low. Perhaps seminoma is an

exception, as with well planned radiotherapy the results are quite promising. In Wilm's tumour the results are very disappointing. Lymphosarcomas and Hodgkin's disease are probably never cured, although lymphosarcoma may be very occasionally. In both conditions long periods of relief can be obtained, sometimes up to ten years or longer.

In the next group radiotherapy is given as the treatment of choice because, although the tumours are relatively insensitive compared with group I*a* they are usually small growths when first seen and are accessible. Consequently a high dosage can be used with accuracy and safety. These tumours can of course be treated successfully by surgery, but on the whole radiotherapy is usually preferable, and failure with radiotherapy still permits surgery as an additional treatment. With the exception of the maxillary antrum and the vagina the cure rate is high in reasonably early cases.

I*b*.—*Radiotherapy treatment of Choice.*

Tumours of moderate sensitivity, but of *small volume in accessible sites*.

Carcinomas.

Mouth, tongue, lip.	Cervix uteri.	Maxillary antrum.	Retinal glioma.
Skin of face and hands.	Vagina.	Larynx.	

In view of the recent controversy on skin carcinoma in the medical press, a little more detail may be of interest on these tumours. It is of course quite true that rodent ulcers can, in theory, be excised completely with no danger of recurrence. If treated by radiotherapy a recurrence rate of some 5 per cent. must be expected, even with small ulcers. It is doubtful if surgery can improve on these results although they can probably be equalled. Radiotherapy is advocated as the treatment of choice for skin carcinoma on the hands and face, because in these areas less deformity and loss of function would result than is possible by surgery. Only the actual tissue destroyed by the rodent itself will be lost and even islands of healthy tissue in the area should and do survive. Carcinoma of skin elsewhere on the body is equally treatable by surgery or radiotherapy. If the lesion can be easily excised, surgery may well be quicker and simpler, although with modern apparatus it is often possible to treat a small rodent in literally a matter of seconds, with very little discomfort to the patient. In some cases of surgical excision it is often wise to follow excision with radiotherapy and so make assurance doubly sure. This procedure is often referred to as biopsy excision and the excision need not be quite as wide or drastic as if surgery is used alone. Clearly it is foolish, as in all branches of medicine, to be dogmatic on this subject. Individual skill, the availability of treatment and, let us be honest, even prejudice will influence the decision !

The next group of cases is one in which surgery and radiotherapy combined will give the best results :—

II.—*Surgery combined with radiotherapy.*

(*a*) *Predominently surgery.*

Carcinoma of breast.
Secondary carcinoma of lymph nodes (particularly head and neck).
Mixed tumour of the parotid.
Osteogenic sarcoma.

(*b*) *Surgery and radiotherapy, alternatives or combined.*

Carcinoma.
- Body of uterus.
- Vulva.
- Penis and scrotum.
- Skin of trunk of limbs.

Osteoclastoma.

As has been stated earlier, in all cases of cancer it is highly desirable that everyone interested in cancer should work in the closest possible collaboration. In this particular group of patients I believe, if the best results are to be obtained, it is absolutely essential that the radiotherapy department and the surgeons should work with complete co-operation.

In this group of tumours radiotherapy can improve the results of surgery and can also sometimes, when used pre-operatively, bring cases back into the operable stage and give the patient a chance of permanent cure.

In stage one carcinoma of the breast in which the glands are proved to be free from growth after microscopic examination, radiotherapy is usually not required. The results of skilful surgery in these cases are excellent and cannot be improved by radiotherapy. In all other stages radiotherapy can help to improve the results of surgery, either as a pre- or post-operative procedure.

Secondary lymph nodes, particularly in the neck, give poor results from both surgery and radiotherapy. A combination of the two is probably the most hopeful line of attack. In the neck radiotherapy is handicapped by the difficulty of irradiating a relatively large volume of tissue, containing the larynx, trachea and pharynx. Dosage has to be rather low. With improved techniques a few more cases may be saved, but at the present the results, even from a palliative point of view, are very disappointing. In mixed tumours of the parotid, pre-operative radiation reduces the recurrence rate very considerably. As in all pre-operative radiation, close collaboration is required to ensure that the optimum time for the operative procedure is chosen. If this is done there should be no difficulty in healing or significant increase in the difficulty of operation.

The prognosis in osteogenic sarcoma is very grave, but a combined attack may save a very few cases.

III.—*Radiotherapy rarely curative but of palliative value.*

Hypernephroma.
Carcinoma of the ovary.
Carcinoma of the larynx stage 2 and 3.
Carcinoma of the bladder.
Thyroid tumours.
Salivary gland tumours.
Ethmoid tumours.
Carcinoma of the pharynx.
Carcinoma of the œsophagus.
Primary carcinoma of the lung, if reasonably early.
Mediastinal tumours.
Bone metastases if not too extensive.

In this group radiotherapy is rarely curative but it has a high value as a palliative measure. In selecting cases for palliation care is needed and the remarks made earlier about palliation must be born in mind. Carcinoma of the œsophagus in selected cases is a good example of palliation. It is extremely rare for a case of carcinoma of the œsophagus to be cured by radiotherapy. On the other hand, in selected cases it is often possible to get a return to normal, or near normal swallowing, for a period of as long as two or even three years. When death follows it is usually rapid and less unpleasant than the slow starvation so often seen in untreated cases. With careful selection, much can be done for carcinoma of the lung and with new techniques and the use of penicillin to control the danger of secondary infection during treatment it may become possible to improve the results of treatment. Mediastinal tumours are usually worth treating, at any rate as a palliative measure since the exact diagnosis is often not known. A number of these prove to be very sensitive and are lymphosarcomatous in nature. It is true to say that, if a mediastinal tumour is going to respond, it does so fairly early in treatment and the decision can be made then whether to press the treatment to a high level or be content with a moderate dosage.

Bone metastases are, on the whole, well worth treating as a palliative measure, unless they are very extensive. Pain can usually be relieved more or less completely and even if a pathological fracture is present union sometimes occurs and palliation sometimes lasts a matter of years. If the deposits are very widespread, radiotherapy can do no good.

IV.—*Radiotherapy generally useless.*

Fibrosarcoma.
Myosarcoma.
Liposarcoma.
Melanoma.
Carcinoma of the stomach.
Carcinoma of the bowel generally.
Carcinoma of the prostate.
Secondary carcinoma of the lung, except seminoma and embryonal tumours.

This last group is given with some hesitation. It has already been stated that each individual case must be considered, but on the whole radiotherapy does no good in these patients and can do harm. However, some fibrosarcomas are much more sensitive than the average and may give some, if temporary, response.

Extensive and drastic surgery probably offers the only hope for melanomas. As a rule they are almost completely insensitive to radiation at the dosage which can be given with any safety. Very occasionally some response is obtained but it is rare. In carcinoma of the stomach and alimentary tract as a whole it is usually useless and tends to make the patient even more uncomfortable.

(Some coloured slides were then shown to illustrate points in the lecture).

Dr. Roderigo Lopez

1525–1594

By IVOR S. MOSS.

DR. RODERIGO LOPEZ, a Portuguese Jew, is said to have been captured by Drake during one of his anti-Spanish forays, and brought to England as a prisoner in 1559. He speedily attained fame in the practice of medicine and by 1567 he was the first resident physician to St. Bartholomew's Hospital. Before 1569 he was a Fellow of the College of Physicians and was even selected in 1570 to read the anatomy lecture, an honour which he declined, paying the subsequent fine.

Five years later he was acknowledged as one of the leading physicians in the metropolis, and shortly afterwards was appointed chief physician to the Earl of Leicester. Lopez maintained contact with his friends and relatives on the Continent and about this period he married Sarah, a Jewess of Antwerp.

In 1586 Lopez was appointed chief physician to Queen Elizabeth who granted him a monopoly in importing anise-seed and sumac ! At court Lopez rapidly became acquainted with the leading statesmen and courtiers of the day. The death of Leicester had elevated the Earl of Essex to the position of chief favourite of the Queen, and with Essex, Lopez became intimate. The ambitious young favourite, not content with his success as a courtier, was anxious also to shine as a statesman. In order to give his talents in this direction opportunity for display, he thought it advisable to obtain a private supply of secret information, especially with regard to Spanish affairs. In pursuance of this policy, Lopez and his continental agents must have appeared extremely useful, and Essex accordingly applied to him for assistance. Lopez was, however, unwilling to take any part in the business, and disclosed Essex's communications to the Queen, much to that nobleman's chagrin.

In another matter, however, Essex found Lopez more amenable. Essex's policy was one of promoting hostility towards Spain, and he used Lopez as an interpreter to Don Antonio Perez, the pretender to the throne of Portugal and a fugitive from Spanish persecution. For a time Lopez became closely connected with the households of Essex and Antonio. Disputes, however, arose between them and the atmosphere was not cleared by a disclosure on the part of Lopez to Antonio and others, of some professional secrets concerning Essex " which did disparage to his honour."

Spanish spies in Antonio's entourage enlisted Lopez in an attempt to rid Phillip of Spain of a claimant to the Kingdom of which Phillip had taken possession. Lopez seems to have entered into it so far as to state that Antonio would not recover from his next illness ! Later a suggestion was made that the death of Elizabeth would also cause considerable pleasure to the Spanish king. This suggestion Lopez refused altogether to consider and let hints of the movement drop in Elizabeth's presence.

The sordid affair drew on. Essex had Lopez " put on the rack " to obtain a confession from him which was afterwards withdrawn. Charges of Spanish machinations were always pleasing to the populace and as a matter of course Lopez was found guilty. The evidence was extremely shaky and Elizabeth reprimanded Essex as a " rash and temerarious youth to enter into a matter against the poor man which he could not prove." The whole affair created so much excitement that no less than five official accounts, one by Bacon, then in the service of Essex, in addition to numerous private ones, were published.

An interesting and full account of the charge of treason against Lopez and of his innocence is given by Lytton Strachey in " Elizabeth and Essex."

For some months the Queen could not be induced to sign the death warrant. When she eventually consented to do so, she did not claim her right to the condemned man's property. With the exception of a ring, said to have been given to Lopez by the King of Spain, which Elizabeth wore until her death, she allowed the widow to retain the whole of her husband's estate.

Lopez lived during an interesting period of English literature. He was certainly known to Shakespeare and some authorities connect him with " The Merchant of Venice." He found mention in many plays—Marlowe's " Dr. Faustus " and Dekker's " Whore of Babylon," to mention only two of about half a dozen that we still know of to-day.

Although Bacon was never well disposed towards him, he regarded him as "A man very observant and officious, and of a pleasing and reliable behaviour." William Clowes, a contemporary at Bart's refers to him in his book on "Gunshot Wounds," 1591. "He showed himself to be both careful and very skilful, not only in his counsel in dieting, purging and bleeding, but also for his direction of Arceus Apozema which he has caused us to adopt at St. Bartholomew's." Another contemporary, Gabriel Harvey, had a rather different opinion of him, which he framed in the following manner :—

"Doctor Lopus, the Queenes Physitian, is
Descended of Jewes : but himself A
Christian, and Portugall.
He none of the learnedest, or expertest
Physitians in ye Court : but one, that
Maketh as great account of himself, as
The best : and by a kind of Jewish practis,
Hath growen to much Wealth, and sum
Reputation : as well with ye Queen herself,
As with sum of ye greatest Lordes,
And Ladyes."

Lopez was indeed a remarkable character.

The Steele Diaries—VII

PATIENTS—(*continued*)

20th January, 1875.

There has been an unusually long series of surgical operations performed during the year. The number of operations registered has varied during the last 10 years from 300 to 350 which latter figure it reached in the year 1873, but during the past year the number entered in the operation list has exceeded 600. As many of the operations were of minor importance though requiring Chloroform, they have not been considered worthy of tabulation, but 540 of the number have been entered on the abstract tables. The large number of entries are attributable to several causes. The duty of entering the cases formerly fell to the Surgeryman who was not always cognisant of what occurred in the wards. During the past year this duty has been performed by successive House Surgeons who have entered nearly every case in which they have been called on to administer Chloroform. A larger number of severe accidents requiring immediate amputation have been admitted during the past year than has been the case in previous years and, lastly, the surgeons and especially the assistant surgeons, have practiced on a larger scale than formerly the resection and amputation of diseased joints as well as other minor operations.

Among the more important operations were 93 amputations of which 22 died, 7 of the amputations were double or involved two extremities of which 1 case was successful.

Ovariotomy was performed 13 times during the year and was attended with 6 recoveries, Lithotomy 8 times with 6 recoveries.

Resection of Joints was performed 42 times with 6 deaths and 32 cancerous breasts were excised with 25 recoveries.

Tracheotomy was performed in the medical and surgical wards 14 times with 4 recoveries, Abdominal Section and Colotomy 3 times and 2 of the patients lived 5 and 12 months respectively after the performance of the operation.

There were 3 deaths from the administration of Chloroform during the year.

26th January, 1876.

Unfavourable comments are frequently made on the way in which the bodies of deceased patients are removed from the wards to the Hospital Deadhouse, and it has often been suggested that greater privacy should be observed in their transference. It is not easy to see how this can be done but a circumstance which occurred last Friday night and which seriously alarmed the patients of Martha Ward might be avoided by proper precautions. In this case the men employed to remove the body, unfortunately allowed the coffin to slip off their shoulders and the body, a particularly heavy one, to roll out on the Ward floor.

29*th November*, 1876.

The Cæsarean Section was performed for the second time this year on Friday night last on a patient in the spare room of Addison Ward.

27*th December*, 1876.

An intimation was sent from the London Hospital on Thursday last that a patient had died in that Institution from fractured ribs and collar bone, who had been brought to Guy's Hospital on the previous week on the receipt of the injury and having been told by the House Surgeon on duty that there was nothing wrong with him. At the inquest held on the patient last Saturday, Mr. Barrs, the dresser on duty, gave evidence to the fact of his having carefully examined the man and could find nothing wrong with him. The jury returned an open verdict, there being no evidence to show how the accident which caused death was sustained.

Monday last being Christmas Day, the patients in the Hospital had their usual Christmas fare, consisting of roast beef and plum pudding in lieu of the ordinary diet allowed them. Although the change of diet was further supplemented by fruit in the way of dessert, and in the case of the male patients with a considerable consumption of tobacco, there has been no instance reported in which the temporary change has been attended with injurious consequences.

14*th March*, 1877.

Considerable excitement was caused in the Hospital on Sunday, in consequence of a man suffering from Hydrophobia having been admitted to Astley Cooper private room. After severe maniacal struggling and suffering the patient died on the following morning. It is proper to notice that though the patient had been attending the Surgery after the bite from the dog, the part had not been cauterised by the House Surgeon.

30*th May*, 1877.

The old couch or bench on which it has been customary to perform the operation of Ovariotomy is in very much need of being recovered. It might also undergo some alterations with advantage.

5*th September*, 1877.

The patients and other residents were kept awake a considerable part of the nigh last Sunday by the screams of a patient in the Surgery, to whom electricity was being applied to discover whether the man was drunk or suffering from the effects of a fit. It would be an immense boon to the inmates of the Hospital generally, if the screams and groans originating usually from drunken people brought to the Surgery by the police could in any way be mitigated.

24*th October*, 1877.

Great consternation was occasioned in the Male Clinical Ward yesterday afternoon in consequence of a patient suddenly becoming delirious and smashing several of the large panes of glass. He was secured by some of the workmen from the outside and conveyed to the room used for refractory patients.

17*th July*, 1878.

A good deal of alarm has been felt in Naaman Ward in consequence of a patient having been attacked with peritonitis, apparently attributable to his having partaken of some water cress supplied by the woman who usually sells these articles to the patients. The vendor has been forbidden from entering the ward in future.

19*th November*, 1879.

Some uneasiness has been caused by the death of a woman who was brought to the Surgery on Wednesday last, and who was supposed at the time to be drunk and who was sent away in consequence. The patient was seen by the assistant House Surgeon who advised her to remain in the Surgery till she recovered herself and during his absence (having regained consciousness) the dressers in the Surgery either told her or permitted her to leave.

On her arrival at her home near the Boro' Market, the Surgeon who sent her to the Hospital again examined her and finding her in a critical condition, he came to the Hospital and explained the state of the case to me. I instructed the bathmen to bring her in some conveyance at once to the Hospital where she died in about an hour after admission. The inquest on the case was partly heard on Friday last and was adjourned till Friday next.

The Residents' Play, 1949

The Residents' Play was presented at a later date than in previous years, but "Out for the Count" was a good reward for patient waiting. John Trounce's second play was better than his first. It provided an evening of high-class entertainment and amusement such as can come only from this unique tradition of Guy's. The plot was "thin," sometimes difficult to follow, and confused by the meanderings of three eminent obstetricians who seemed to have no greater purpose than to seek a rubber fœtus which had mysteriously disappeared. The main theme concerned the activities of a group of villainous body-snatchers, headed by Dr. Rompers, Dr. Neversqueeze and Dr. Hoodwink, who were opposed by Mr. Dedley Ratkins and the Hero and Heroine. This theme, supported by a witty script, good stage-craft and some excellent acting, gave us full measure of laughter and merriment. The music, written by Dr. Hills, was rendered by voices much above the standard we expect in a Residents' Play. We never fail to admire the versatility of Dr. Hills as a composer and his music in this play was more melodious and of wider range than that we heard last year. In support of Trounce and Hills, and undoubtedly stimulated by them, Michael Price showed himself an admirable and energetic producer. He got the best out of a hard-working cast, his dances were excellently arranged and executed, and his actors were well disciplined with the possible exception that they were not sufficiently trained to refuse encores to the musical numbers. It is so much better to refuse an encore than to give one which produces an anti-climax; it is a tactical error in a Residents' Play to give an encore unless an alternative lyric is available; and to be led to a second encore is an unforgivable sin. Such criticisms are made in the full knowledge that this is a topical amateur theatrical show, designed to give maximum pleasure and enjoyment to an extremely varied audience, but a standard has been set in Residents' Plays which demands that attention be given to any detail which may lower the tenor of the performance.

In the Residents' Play it is the character-parts which are most remembered, but let us not forget to praise those actors cast in minor roles and those called upon to play the Hero and Heroine. The students' chorus with the Landlord of the Miller (Miller, Dick, Harrison, Keller, Soothill and O'Mahoney), Bill the Coffee-stall Keeper (Jeffreys), the nurses (Hope and Deuchar) and the patients (Hatton and Graham) all helped the play along with their buoyancy and vigour. Williams, the Heroine with the twinkling eyes, gave an admirable performance and was ably supported by Neve, the Hero, in the love-duets. Vaughan, "another house physician," was destined to disappear unexplainedly half-way through the play, but while he was with us he gave real hopes that the Hero would have serious competition in his love-making.

Without drawing invidious distinctions between the other actors, it will be generally agreed that Merryweather, as Dr. Rompers, stole the limelight. His previous stage experience was invaluable and he gave a vigorous and perfect performance, portraying faithfully both the Dr. Rompers we know and, in an unforgetable intoxicated state, the Dr. Rompers we had hardly dared to imagine. Allen was also outstanding as Mr. Dedley Ratkins; he looked the part, walked the part and talked the part to such effect that the television display was an excerpt from real life. Hutchinson, as Dr. Neversqueeze, was beautifully bearded and had all the mannerisms of his prototype, whilst Hume was equally successful as Dr. Thrills. Among the three obstetricians (Finnegan, Joiner and Craigen) Craigen was the most life-like, often reproducing the voice and gestures of Mr. McFlair to perfection. Macrae-Gibson has a difficult task to play Dr. Hoodwink but his script provided the gibes and got the laughs. Trusted, as Mr. Knockoff, and Blundell, as Mr. Kink, made only brief appearances and we were sorry that Blundell's voice was not given greater scope. In the female character parts Porter was an officious and effective Sister Grimbags, and Hart a sedate, but not seductive, Matron. The musical numbers which stood out for their excellence and performance were the "Anæsthetist's Song" (Blundell), "Dreaming over the Coffee Cups" (Neve and Williams), "Romper's Song" (Merryweather), "The Villains' Song" (Merryweather, Hutchinson and Macrae-Gibson) and the "Director's Song" (Allen and nurses). At the pianos Chalk and Bilton played in polished style and behind the scenes a great army of workers made it possible for the play to go on. The original scenery was designed and executed by Daphne Hoeltgen and Peter Griffiths in animated fashion and we thank them for coming to our aid.

"Out for the Count" was undoubtedly a great success and to all who made it so we offer our congratulations and thanks. The Play depends entirely upon the enthusiasm and unstinting labours of the Residents, and each year they must find an author, composer and producer equally enthusiastic and willing to expend an immense quantity of time and energy on the task in hand. The Residents are never found wanting and each year, without fail, their helpers are forthcoming. May it long continue so. Next year, the Jubilee year of the Residents' Theatricals, we shall look forward again to our annual treat and we shall not be disappointed.

Correspondence

De Mortuis.

SIR,—The excellent article on sleep by Dr. Maclean is sure to be read by many students and others with pleasure and profit; I shall be forgiven therefore if in the interests of accuracy I remark that καρόω means, not "I sleep," but "I stupefy," and καρωτίς (carotid), not "the artery of sleep," but "the stupefier." The Greeks were not so simple as to confuse syncope with sleep. I did draw attention to the meaning of carotid not long ago in another publication from our hospital (*Reports*, Vol. 96, Nos. 3 and 4, p. 180). With the pertinacity of Sisyphus I go on to note that there appears in Dr. Maclean's article just the two words that I gave as examples of terms that affront us, "hallucinosis" and "depersonalization" (*loc. cit.*, p. 169). (Of course he is not himself the inventor of them). Hallucinor, better spelt alucinor, is a Latin verb, but —sis is a Greek termination. With —osis in particular I dealt faithfully as the most common of all sources of medical "howlers" (*loc. cit.*, p. 175). A pure word to express the meaning would be halygma, ἀ̓λυγμα, from 'αλύω, or 'αλύω the cognate Greek verb. The guttural has been lost from this verb but would doubtless reassert itself in derivatives (cf. 'αλύσσω fut. α'λύξω). However, I do not believe that any word at all, even a good one, is necessary: if a patient is wandering in mind or subject to hallucinations, cannot one simply say so?

As for "depersonalization," it is the sort of word that any one who cares for pure English ought to cut right out of his vocabulary. Whenever a man is confronted with a verb in —ize, let him ask himself this question: "Must I adopt this brute?" The answer is usually "No."

"Hypersomnia" I have not met before. Hyper is Greek, somnus is Latin, and the suffix —ia is Greek again. A former Professor of English, Raleigh, contemptuously called Science "an old bawd"; but that was when the labels that she applied were still tolerable. I wonder what he would say now! He had considerable powers of expression.

Yours, etc.,

H. St. H. VERTUE.

Orpington, Kent.

Case Presentation.

SIR,—Your correspondent "Dresser" may be interested in the following extract from an address on the opening of the Medical School by Dr. Moxon in 1868:—

"You will have to get and store away in your memories a vast quantity of knowledge. I tremble for you when I think how much, because of the great danger that this bulk of knowledge may be too much for you. It may sink that individual judgment which you must above all things maintain. Knowledge is fuel, not fire. It is excellent fuel: but, by order of the colleges, it will have to be thrust into you in heaps and, unless you take care, it will smother the spark of active intelligence which, if the fuel be added with proper care, will light it all ablaze, to glow upon and cheer your future patients. Mind the fuel does not come faster than you can master it, or you will be more like a coal-scuttle that a fire. Knowledge is but a body of which intelligence is the soul. I fear lest you get more body than you have soul for."

Yours, etc.,

W. M. MOLLISON.

London, W.1.

A Memorial Service.

SIR,—A memorial service was held on Saturday last in the chapel of the Millbank Military Hospital for nurses of the Q.A.M.N.S. who were killed by enemy action during the war.

I think I am right in saying, that among these casualties there were three Guy's nurses—Miss Eileen Ievers, Miss Leech and Miss Pitt.

It was a very beautiful and simple ceremony, the memorial plaque being unveiled by General Slim, and the service being conducted by the Chaplain-in-Chief and the Hospital Chaplain.

The names of the casualties are inscribed on the plaque, and Miss Ievers comes second in the list of matrons. There were lovely large wreaths of Flanders poppies and green lichen moss.

I would like to quote from a letter that Miss Ievers' aunt wrote to me :—

"I was introduced to Dame Katherine Jones, her Matron-in-Chief, who said : 'She (Miss Ievers) was a great personality, a wonderful nurse, loved by all who knew her and worked under her. Truly I am proud to have had them under my command, and I think I nearly broke my heart when I had to write those letters to you all.'"

Yours, etc.,

KATHLEEN A. SHACKLE.

5, Bracknell Gardens, N.W.3.

Guy's Diary

ACADEMIC

JUNE.

Exhibition. Surgical Department. "Rectal Bleeding."

20th. 1.00. Dr. Mark Ravitch. Clinical Lecture. "Surgery of the Lungs and Thoracic Parietes in Children."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

21st. 1.00. Dr. Mark Ravitch. Clinical Lecture. "Pot Belly in Children."

23rd. 1.00. Mr. Lawrie. Clinical Lecture. "Surgical Negligence."
4.30. X-ray Meeting. Gordon Museum.

24th. 1.00. Dr. Doubleday introducing Dr. Robert Forbes, Secretary Medical Defence Union. Clinical Lecture. "Legal Hazards in Medical Practice."

25th. 10.00. Surgical Department. Clinco-Pathological Meeting. Anatomy Theatre.

27th. 1.00. Dr. Hills. Clinical Lecture. "The Stomach and the Radiologist."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

28th. 12.00. Neurological Demonstration. Preclinical Classroom.

29th. 3.00. Unveiling of the statue of Viscount Nuffield by Lord Goschen.

30th. 4.30. X-ray Meeting. Gordon Museum.

JULY.

Exhibition. Surgical Department. "Diseases of the Hip."

1st. 1.00. Dr. Lilienthal. Clinical Lecture. "Anoxæmia."

4th. 12.00. Surgical Staff Conference. Clinical Theatre.
1.00. Dr. McArdle. Clinical Lecture.
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

SPORT

JUNE

26th. 11.30. 1st XI. *v.* Bognor Regis (Away).

JULY

2nd. 2.30. 1st XI. *v.* Ealing Dean (Away).

3rd. 2.30. 1st XI. *v.* Streatham (H.O.P.).

Book Reviews

Introductory Botany. By ALEXANDER NELSON. Livingstone. *Price 22s. 6d.*

This book is intended both for students of pure botany and those seeking general biological principles. Much of the treatment is too superficial to form a sound basis on which the student of pure science could build, and far too many types are included without any emphasis on the biological principles they show to recommend the book to those starting biology.

The layout is attractive, diagrams clear and there are useful chapters on physical and chemical principles, but the book is marred by frequent errors. For example, irritability is not included among the characteristics of living organisms, the usual errors in the account of cell division are repeated and the importance of controls in experimental work is entirely overlooked.

The book cannot be recommended.

B.J.R.

The Essentials of Orthopædics. By PHILIP WILES. Churchill. *Price 42s.*

Here is a clear account of the commoner orthopædic conditions. With 475 pages and much space taken by the 365 illustrations, it is of necessity limited to the "Essentials." Fractures are not dealt with. But within this framework, the author has been very successful in describing "the physiological and pathological basis of orthopædics and its application to diagnosis and treatment" in respect of the various conditions described.

The subject is dealt with from an up-to-date point of view, and space has not been wasted in describing "classical" procedures now out-moded. The book helps to fill a long felt gap in the orthopædic literature.

P.G.E.

Groves and Birkdale's Textbook for Nurses. By J. A. NIXON and SIR CECIL WAKELEY. 7th Edn. Cumberlege. Oxford Medical Publications. *Price 30s.*

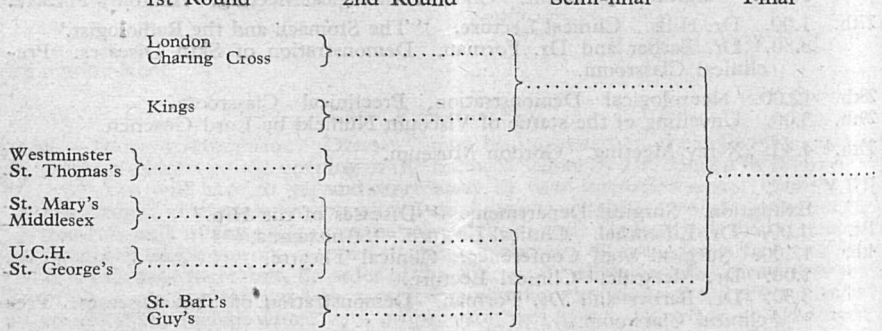
This book is so well-known by nurses as to need no introduction.

In this new edition, the sections dealing with Tuberculosis and Vitamins have been rewritten, and information on virus and infections added. These, together with the excellent anatomical diagrams, the concise descriptions accompanying them, and the sections covering Surgery and Medicine, make this book an asset to any nurse's bookshelf.

A.L.

Inter-Hospitals Cricket Cup

The draw for the Inter-Hospitals Cup this season has been made as follows :—



UNITED HOSPITALS FIXTURES

Wednesday, June 8th	..	Sussex C & G at Hove	
Sunday, June 12th	..	Metropolitan Police at Chigwell	
Wednesday, June 15th	..	Incogniti	at home
Wednesday, July 5th	..	Universities Athletic Union	at home
Wednesday, July 5th	..	Civil Service Crusaders	at home
Wednesday, July 20th	..	Buccaneers	at home

Sport

CRICKET

Inter-Hospitals Cup—1st Round

Guy's *v.* St. Bartholomew's

At Chislehurst. Result—Drawn.
11th June, 1949.

The match commenced with the ritual beloved of opening bats—the maiden over. As the ball passed outside the off stump the batsman lifted his bat in a dignified fashion and stared glassily at cover point. Cairns and Russell decorously and conventionally performed this necessary ceremony.

Cairns' partner obviously a cricketer of no culture smote the first ball from Gray onto the knee-cap of gully who was shocked at this lack of courtesy. Cairns, however, covered up this breach by playing the remainder of the over almost bent double with care and carefulness. His unabashed companion slashed Russell's first ball, yet again at gully, who this time positively flustered, beat it to earth like some insect.

Ken Gray (not the one who plays poker in his hat) then bowled this imposter who had the audacity to attempt scoring strokes, after the fashion of a stern parent taking toys from a naughty child. Bart's 6 for 1.

Tomlinson is not a name one associates with sport, rather does it suggest the bank clerk or the commercial traveller—however the Bart's Tomlinson is the most dangerous batsman Guy's meets in club cricket. So Guy's fielders watched as if paralysed the dreadful duel between Tomlinson and the perspiring Russell. And now a strange little drama was enacted. At one end Russell at the beginning of his run arranged his features to indicate the ferocity customary to fast bowlers. At the other end Blake, the stumper, stood in his symbolically white pads many yards from the wicket. Midway between the two stood Tomlinson almost insultingly unworried. Blake and Russell moved simultaneously, one running forthrightly to deliver, the other slyly creeping up behind the batsman as if to pop a bag over his head. It was a fearful moment as Blake and Russell reached their posts and down came the ball fast, good length and moving quite suddenly away. Forward leaned the batsman, he was beaten, overbalanced a fraction and Blake standing right up flicked off the bails and turned almost shamefacedly to square leg, where, flimsily disguised as an umpire, stood one of the Bart's team. He gave Tomlinson out and Guy's were right on top : 13 for 2.

Now Russell toiled and Gray span but Cairns and Brainbridge stayed there. They were slow but the situation warranted it. They saw Russell pass from red to apoplectic and Gray from pale, gentlemanly elegant and assured to Gray quite frankly hot and even a little tired. But they had bowled valiantly.

Then came the Guy's spinners like clowns to give a little light relief. With the exception of Pichett who turns a pretty ball, they move the ball in the air slightly—with a roaring gale that is—and the tension lessened. Bart's were careful, however, and it was with surprise that Cairns was seen to offer an unaccepted chance to slip and with positive amazement that Brainbridge was seen to be caught in the same place. 3 for 43.

Now came Vazijdar, the courtly Indian, who liked the bowling, hit it around a bit and smiled to the fielders as he did so. However, Cairns continued in his now ludicrously slow innings and very unusually just before lunch hit a shortish ball from Pichett straight at Gilbert who had cunningly hidden behind the square leg umpire. 75 for 4 in 2 hours ; Cairns 32.

By 3.15 Bart's were 108 for 7 and Gray was 4 for 20. Good bowling this and Guy's felt that they had won.

Alas, Guy's were tired and a sharp shower really eased out the wicket so that Bart's, who had already taken three hours to score a hundred, took a further 2¼ hours to reach 170 in the most unenterprising manner possible, thus killing the game.

It remained for a tired Guy's who had fielded from 11.30 to well after tea to play out time. In doing so, Blake scored a sacrilegious 28 in 20 minutes off the opening overs and Gilbert gave a free lesson in how to play slow bowling by moving one's feet. Also worth quoting is Gray's analysis, 25.3 10 35 5, and the predatory fielding of Lipington at cover might well be copied by many county fielders.

1st XI. *v.* Honor Oak

May 7th, 1949.
at H.O.P. Result—Lost.
Honor Oak 194 ; Guy's 141.
(Woodford 46, Russell 3—65, Lipington 4—50).

1st XI. *v.* Ashtead

May 8th, 1949.

at Ashtead. Result—Drawn.
Ashtead 192; Guy's 179—8.

(Williams 51, Woodford 37, Russell 3—29).

The delightful Ashtead ground, in ideal weather, made a perfect setting for cricket, and the local inhabitants were out in strength to watch. Ashtead chose to bat, and made a shaky start with 4 wickets down for 35, against some excellent bowling by Russell and Gray. But poor fielding robbed us of the initiative and runs came quickly. Street made a century for them before Meyer caught him and their innings was closed.

Blake hit the first ball for four but was bowled before getting into his stride. Gray joined Woodford and took the score to 61 before being caught on the boundary trying to repeat a six he had hit a few balls before. Williams, batting very attractively, came in and made 50, but the tail could not quite get the runs needed before stumps were drawn.

1st XI. *v.* Stoics

May 11th, 1949.
at H.O.P. Result—Drawn.

Stoics 165; Guy's 130—8.
(Blake 36, Russell 3—33, Smith 4—29).

1st XI. *v.* Wadham College

May 14th, 1949.
at Oxford. Result—Lost.

Wadham College 161; Guy's 118.
(Lipington 30, Tweed 4—42).

1st XI. *v.* Private Banks

May 21st, 1949.
at H.O.P. Result—Lost.

Guy's 103; Private Banks 134—4.
(Pickett 33 not out).

1st XI. *v.* Old Blues

May 22nd, 1949.
at H.O.P. Result—Drawn.

(Russell 33, Gray 32, Gray 5—30).

1st XI. *v.* Bognor Regis

June 4th, 1949.
at H.O.P. Result—Won.
Bognor 90; Guy's 91—7.

(Woodford 31, Russell 5—11, Woodford 4—25).

1st XI. *v.* Finchley

June 5th, 1949.
at Finchley. Result—Lost.

Guy's 135; Finchley 136—5.

1st XI. *v.* Crofton Park

June 6th, 1949.

at H.O.P. Result—Drawn.

Guy's 229—7 dec.; Crofton Park 209—8.
(Blake 68, Russell 68, Russell 3—28, Tweed 2—33).

2nd XI. *v.* Private Banks 2nd

May 21st, 1949.

at Catford Bridge. Result—Lost.
Private Banks 149; Guy's 60.

2nd XI. *v.* Crofton Park 2nd

June 6th, 1949.

at H.O.P. Result—Won.

Crofton Park 76; Guy's 77—5.
(Martin 38, Hodson 7—39, Carter 3—21).

2nd XI. *v.* Inns of Court 2nd

June 11th, 1949.

at Crofton Park. Result—Won.

Inns of Court 2nd 183—5; Guy's 184—6.
(Harris 96, Harris 3—18).

On a brick-like wicket, Inns of Court batted first and made a formidable score before declaring shortly after tea. This score was unfortunately aided by some poor fielding by Guy's. With 2¼ hours to score 184, Guy's hopes dropped when two wickets were down at 54, and the rate of scoring dropped.

Harris, who opened, played a fine innings from the start, and by sound hitting and running between wickets the score was pushed up until he played on when four short of his century.

Then followed some lusty hitting, until with seven minutes to go, Croft selected a ball on his middle stump and sent it to the boundary for the winning run.

ATHLETIC CLUB

GUY'S ANNUAL SPORTS

The Annual Sports will be held this year for the first time since 1939. An attractive programme has been arranged which will appeal to all sections of the Hospital. The physiotherapists, who won the Ladies' relay in 1939, are challenged this year by the nurses, by the radiologists, and by the women students. An inter-club relay (4 × 110 yards) will be held, and also an inter-hospital mile-medley relay. Club secretaries are requested to send in the names of their runners within the next fortnight. The Borough Market Sports Club will run their basket race,

and prominent athletes are coming to compete in an Invitation Mile.

All members of the Hospital are urged to enter their names on the lists in the Colonnade for track and field events. Entries for the mixed 3-legged, sack and obstacle races will be taken on the field. Prizes will be awarded for each event. Other attractions include sideshows run by individual clubs of the Hospital.

The meeting will be held at the Sports Ground, Honor Oak Park, at 3 p.m., on Wednesday, July 13th. Tea and refreshments will be obtainable at the Ground.

UNITED HOSPITALS ATHLETICS

At the United Hospitals Championships on June 11th the following Guy's men gained points for the Hospital: B. Hartley —3rd in 440 yards Hurdles, 6th in Mile; G. Baker—3rd in Hammer; E. N. McKenzie—4th in 440 yards; T. G. L. Thomas—4th in Long Jump; 6th in 220 yards; J. V. V. Lewis—6th in 880 yards; A. A. Roe—2nd in Shot. Our Tug-of-War team was defeated by London Hospital.

G. A. E. Baker,
Hon. Sec.

BOXING

The Inter-Hospitals Boxing Championships were held in the Pavy Gymnasium on 31st May, 1949.

The Boxing Club retains the cup (which was won in 1939) beating, by a comfortable margin, London Hospital, the runners-up.

The results were as follows:—

Guy's Hospital	23 points
London Hospital ..	12 points
St. Mary's Hospital ..	11 points
Westminster Hospital ..	4 points

The Hospital succeeded in taking championships in the Light-weight, Welter-weight, Middle-weight, Cruiser-weight and Heavy-weight classes, thus showing an overall superiority in Hospital Boxing.

C. Halamandres beat A. W. Gelpke (St. Mary's) in the final of the 9 stone 7 lb. class.

The winning of a championship obviously is no new experience for Costa Halamandres. He has shown us that by using his speed and skill he can outbox one of the best lightweights in Hospital boxing.

M. Mason lost to M. Wheatey (Westminster) in the semi-final of the 10 stone class.

He was unlucky in receiving some hard punches in the first round which unsettled him for the rest of the bout.

W. M. Sheeran (Captain) beat D. S. Davis (London) and W. A. Murphy (St. Mary's) to gain the 10 stone 7 lb. championship.

The eliminating bout with Davis was a tougher affair, especially at close quarters, than the final in which Sheeran's chief task was to pin an elusive and skilful boxer long enough to measure and hit. The Guy's captain used his experience, manœuvred his opponent coolly and hit with both hands very hard indeed, bringing off a decisive victory. Sheeran's consistent boxing has been largely responsible for Guy's post-war successes.

R. C. C. Thompson beat E. S. Wakefield (St. Mary's) and F. E. Day (London) to win the 11 stone championship.

A very creditable accomplishment for his first year at the Hospital. His bouts showed that consistant training and determination can go a long way towards successful boxing.

D. M. Lipington beat S. Somens (Westminster) and lost to J. G. Bradford (St. Mary's) in the final of 12 stone class.

In the latter bout he used the ring skilfully to evade some strong attacks from a forceful and more experienced opponent. This was a performance which is a credit to a new Vice-Captain of the Club who was unable to spare time for training.

H. St. John gained a "walk-over" in the 12 stone class.

It is regretted that an opponent was not available because he has shown good boxing ability throughout this season.

A. C. de B. Eksteen beat D. D. Millen (St. Mary's) in the final of the Heavy-weight class.

Congratulations must go to this boxer who at short notice undertook to represent the Hospital in this event. The meeting of two bearded boxers is a rarity and this proved to be one of the most enjoyable bouts of the evening.

Mr. Dickson Wright, the President of the United Hospitals Boxing Association, when thanking the officials, said that he looked forward to the coming season when these championships will be held on a pre-war scale. He then presented the cup to the Captain of the Guy's Hospital Boxing Club, and this concluded a good evening's entertainment.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the following appointments to the Junior Staff, appointments to date from 1st October, 1949, except where otherwise stated.

Assistant to the Director (Senior) of the Department of Surgery
Assistant to the Director of the Department of Anæsthetics
Assistant to the Director of the Department of Obstetrics
Assistant to the Director of the Student Health Service
Casualty Surgeon
Tutor in charge of the Preliminary Clinical Period Class
Medical Registrar (4)
Surgical Registrar (3)
Anæsthetic Registrar
Obstetric and Gynæcological Registrar
Registrar (P/T) Ophthalmological Department (4)
Registrar (W/T) Dermatological Department (to start as soon as possible)
Registrar (W/T) Department of Diagnostic Radiology
Registrar (W/T) Neurological Department
Registrar (W/T) Orthopædic Department
Registrar (P/T) Orthopædic Department
Registrar (P/T) Cardiac Department
Registrar (P/T) B.M.R. and Endocrine Department
Registrar (W/T) Genito-Urinary Department
Registrar (W/T) Physiotherapy Department
Registrar (P/T) Physiotherapy Department
Registrar (W/T) Pædiatric Department
Registrar (P/T) Ear, Nose and Throat Department (2)
Registrar to the Hæmatological Department
Registrar (W/T) Evelina Hospital
Registrar (P/T) Ear, Nose and Throat Department, Evelina Hospital

V.D. Department
Assistant Director
Medical Officer (Male)
Medical Officer (Female) (2)

Department of Clinical Pathology
Chief Assistant
Assistant Clinical Pathologists (3)

Department of Chemical Pathology
Assistant Lecturer (2)
Demonstrator

Department of Morbid Anatomy and Histology
Assistant Lecturer (Gull Student)
Demonstrator (2)

Anatomy Department
Assistant Lecturer
Demonstrator (W/T)
Demonstrator (P/T) (3)

Biology Department
Assistant Lecturer

Chemistry Department
Assistant Lecturer (3)
Demonstrator

Physics Department
Assistant Lecturer (W/T)
Assistant Lecturer (P/T)
Demonstrator

Physiology Department
Demonstrator

Forms of application are obtainable from the Medical School Office and should be lodged with the Dean *not later than 22nd June*, 1949.

Applications are invited for the post of **Assistant in the Department of Diagnostic Radiology.** Appointment for two years in the first instance. Duties to commence on October 1st, 1949. Salary at the rate of £1,000 per annum, to be adjusted when the Ministry of Health scales come into force. Applications, accompanied by the names of three referees, should be sent to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than June 27th, 1949.

Applications are invited for the post of **Registrar, whole-time (B.1), in the Radiotherapy Department.** The salary will be at the rate of £600 per annum, which will be subject to revision when the National Health Service scales for Trainee Specialists are implemented. Applicants should hold a higher qualification in Medicine or Surgery. Duties will commence on September 1st, 1949, and the appointment will be for a period of one year in the first instance. Applications from practitioners holding B.1 posts cannot be considered unless ineligible for H.M. Forces. Applications, accompanied by three testimonials, should be lodged with the Superintendent, Guy's Hospital, S.E.1, not later than June 28th.

Applications are invited for a Whole-time **Research Studentship** at Guy's Hospital, to carry out physiological and clinical investigations into congenital heart disease. Salary £550 to £750 per annum according to experience. Duties to commence about 1st October, 1949. Applications, giving the names of two referees, to be sent to the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than 9th July, 1949.

JOYCE GREEN REUNION

The Staff of Joyce Green Hospital will be glad to welcome any Guy's man who has been associated with Joyce Green Hospital to the Annual Reunion and Prize-giving, to be held on Saturday, July 16th, 1949, at 3.30 p.m. Dancing 9 p.m. till midnight. R.S.V.P. to Matron.

PASS LIST

UNIVERSITY OF LONDON

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.
April, 1949.

Honours.

* I. E. Evans.

* Distinguished in Applied Pharmacology and Therapeutics.

Pass.

T. B. Brewin	R. G. Nicholson
J. G. Brice	A. H. Phillips
R. MacL. Brown	N. H. Porter
P. Buri	H. H. Richards
B. G. B. Christie	A. E. Richardson
J. H. Evans	A. J. Salmon
R. W. Glenn	E. J. Stafford
M. H. Handoll	A. G. I. Stockley
R. Handy	B. Taylor
J. A. B. Jones	C. S. Ward
L. C. Kreeger	D. R. C. Willcox
A. E. McLauchlan	J. D. Williams
A. H. Mendoza	J. L. Williams
	F. R. H. Wrigley

Supplementary Pass List.
Part I.

J. H. McL. Buckley	D. M. Lewis
J. C. B. E. Carreras	J. A. Loeb
P. R. Chalk	R. L. Luffingham
O. F. Conran	C. R. Lynn
J. P. Crawford	M. Mason
J. D. Crowle-Smith	E. W. Melia
I. B. Davies	D. S. Noble

P. R. Dove
A. T. T. Forrester
M. C. Gilbert
B. Hartley
K. R. Heber
E. T. King
J. A. Payne
G. F. M. Pierce
P. B. Poole
J. K. Price
T. I. Rowland
G. W. Scott

Part II.

J. E. Breese
D. M. Carnegie
P. R. Chalk
J. P. Crawford
P. R. Dove
F. G. Ellis
H. A. Hurwood
L. Jacobs
P. G. W. A. Lommerse
E. J. McGuire
A. A. Mason
D. G. May
J. D. Morris
I. S. Moss
D. J. Rudman

Part III.

A. A. Craigen
E. S. Foote
J. R. Greaves

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

May, 1949.

Surgery.

* D. Redpath.

Medicine.

R. J. Aspinall
C. D. Bulstrode

Midwifery.

R. J. Aspinall
M. P. Cardew
D. J. Joubert
E. T. King

* Has completed the examination.

APPOINTMENT

FACULTY OF OPHTHALMOLOGISTS

Mr. Frank Law has been elected President for 1949–50.

CHANGES OF ADDRESS

L. R. McLaren, M.B., B.Ch., 26, London Road, Chelmsford.

John G. Stebbing, M.B., B.S., 25, Thornburn Square, S.E.1. (Tel.: Bermondsey 2068.)

W. J. Wolfsohn, L.D.S., 55, Bryanston Court, Up. George Street, W.1 (Surgery), and 50, Gt. Cumberland Place, W.1 (Residence). (Tel.: PAD. 6223 and AMB. 3577.)

PAPERS BY GUY'S MEN

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Wheatley, David. Penicillin by the subcutaneous route. 1949, **162**, 508.

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BIRTHS

BUTTERFIELD.—On June 7th, 1949, at Tiverton and District Hospital, Devon, to Jean (née McGahey), wife of Fred Butterfield, L.D.S., Eng.—a son (Fred Michael), a brother for Joan.

BEATON.—On 15th May, 1949, at Nuffield House, to Barbara, wife of S. G. Beaton—a daughter

KEDGE.—On June 1st, 1949, at "Netherwood," Solihull Hospital, Warwickshire, to Janet (née Summers), wife of Robert W. M. Kedge—a second son (Timothy Robert).

ROBINSON.—On May 20th, 1949, at University College Hospital, to Esla (née Allen), wife of David James Robinson—a daughter (Davina Ann).

MARRIAGES

McGUIRE—SANDERS.—On Saturday, May 21st, 1949, at St. Gertrudes, S. Croydon, E. J. McGuire to Rowena Sanders.

WINGATE—HOGG.—On 28th April, 1949, at Kitwe, N. Rhodesia, George H. R. Wingate, of Pagham, Sussex, to Jean M. Hogg, M.C.S.P., of London

EDS. { H.A.R. R.G.

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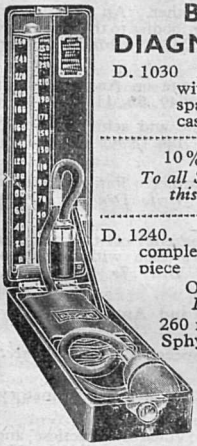

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GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXIII. No. 1590 *2nd July 1949* *Ninepence*

PASSIM

VISCOUNT NUFFIELD
PRESIDENT BENEFACTOR AND FRIEND
OF
GUY'S HOSPITAL

THE afternoon of Wednesday, June 29th, 1949, was a great day in the social life of Guy's Hospital, a day built around the unveiling of the statue of Lord Nuffield, of which a photograph will be found elsewhere in this issue.

When it was announced a little while ago that, to mark this occasion the Hospital and its servants were to be " at home " to their friends and acquaintances, no one was quite certain on what scale it was to be. The activities of the Works Department in the ten days prior to the ceremony, however, made it clear that Guy's was to entertain in a big way. A new surface was put down on the roadway in the Park. Piles of sand and cement and scaffolding gradually disappeared and the Hospital in general underwent sundry ablutions. In the West Quadrangle of Guy's House, around the statue, awnings were erected and a dais grew. Finally when a marquee went up on the main lawn, and a bandstand on the grass in front of the massage department, everyone knew that it was to be no picnic tea.

The Hospital grounds began to fill up at about a quarter past two o'clock. Ladies and other guests gradually took their seats for the ceremony, while the staff of the hospital and schools robed in the Medical School Committee Room. At a quarter to three they walked in procession across the Park to their seats, reflecting in their apparel as fine and diverse a collection of degrees and diplomas as one could wish to see. Finally, following the Head porter bearing the Hospital Mace came the Platform Party, and the stage was set.

Lord Cunliffe briefly introduced Lord Goschen, whose honour it was to be to unveil the statue. Before doing so, Lord Goschen, for forty-six years one of our Governors, and a previous President, drew attention to some of the benefits which Lord Nuffield had conferred on the Hospital (and he told of his first hand experience of Nuffield House). Lord Nuffield was, however, a benefactor not only of Guy's but of the whole world of medical science. To Guy's he was not only a benefactor but truly the head of the great family of Guy's men and women which stretched throughout the length and breadth of the earth. His statue was erected not only to commemorate what Lord Nuffield had done for us, but for the world of medicine in its widest sense. Having expressed his gratitude to Lord Nuffield he unveiled the statue.

Lord Nuffield in reply described the joy which it had been to him to help Guy's. Medicine, although he had known little of it, had always been, as it were, his hobby, and in doing what he had, he had obtained great pleasure and happiness. Lastly, he paid a fine tribute to Guy's men and Guy's teaching.

In conclusion, Sir Herbert Eason moved a vote of thanks to Lord Goschen, and (we thought) congratulated him on getting out of Nuffield House in such good shape. He reminded us that the sculptor too should be remembered in our gratitude for this fine statue, only the second to be erected at Guy's in two hundred years.

The rest of the afternoon was spent in taking visitors around the buildings and grounds. There was a most admirable atmosphere of hospitality wherever one went, and a more than enjoyable tea. The band of the Coldstream Guards provided excellent music and the sun shone. By six o'clock one could have asked for no more. It was a great day, and we would conclude by congratulating the organisers, and thanking most whole heartedly those of lesser rank but no less industry who by their courtesy and helpfulness throughout the day, really made it a success.

Endocrines and Lactation

By H. A. RIPMAN, M.B., B.S., M.R.C.O.G.

TO play a cricket match on an away ground, and to lose the toss, does not condemn the side to failure, but to play at home is a help towards a successful outcome, and to win the toss gives material as well as moral benefit. Similarly, though all infants who are artificially fed do not fail to survive the first year, a far higher percentage fall by the way than is the case with those children that are breast fed. All is not lost with the failure to establish lactation, but the mother who delivers plenty of milk is providing a home wicket, and the child which takes it well, has won the toss.

A hundred years ago, if a poor mother who could not provide a wet nurse, was unable to suckle her child, there was one other alternative only—raw cow's milk. Bacteriology was an unheard of science, and artificially fed children died in their thousands, particularly in the warmer months, from summer diarrhœa. This may be surmised to have had two significant effects. In the first place to fail in breast feeding was to submit the infant to a considerable risk : as a result, mothers persevered to the limit of their capacity in an attempt to suckle their young successfully. In the second place this weighting of the scales so heavily against the bottle-fed baby must have acted as a potent factor of natural selection. Those babies fed naturally inherited a fine lactation quality from their parents and survived to have young which in turn they successfully fed and kept alive. Those babies which were the offspring of women unable to breast feed perished in much larger numbers in the first year and failed to have children to whom in turn they could hand on their inheritable disability.

This is far from being the case to-day. With the advent and perfection of dried milks, and more particularly since these have been reduced to moderate prices and finally provided by the State, the lethal hazards of being artificially fed have been enormously reduced. To fail in lactation is now not of sufficiently obvious detriment to the child to impress the lay person, and to the generation of doctors now filing into the ranks of general practice, who have never seen a major epidemic of summer diarrhœa, it is not of very apparent import either. At the present time this factor in natural selection is becoming of less and less significance and more and more bottle-fed young are coming to attain the age of reproduction and lactation. The overall result today is that whereas the dresser may see eighty per cent. of the babies he delivers go out of the ward at the end of the first fortnight fully breast fed, there are very few districts where more than half are in this happy state at the end of three months, and in most areas less than forty per cent. rely on the breast at the end of the first half year.

It is a sad state of affairs that so many infants should be playing away matches and losing the toss. In our hospital, and probably in most, obstetric difficulties come by established tradition under the ægis of the doctors and hence form a considerable part of the education of students. By the same tradition, feeding difficulties have come to be managed by the nursing and midwife staff and on that account the student acquires little, if any, practical experience of their management. In fact, all too often the first time he has to apply his mind to the matter is when, having qualified, he is called to a private house to " hold the baby " by himself.

With this in mind, namely, to devote a little attention to the subject of the breasts and lactation, this short article has been conceived, with the full realisation that reference is being made solely to a very small, limited and special aspect of this vast problem.

Development of the Breast.

The breasts develop in the pectoral region as localised thickenings of the ectoderm, the mammary buds. From these buds, finger-like processes of solid columns of cells invade the underlying connective tissue, branching as they proceed, and eventually becoming canalised to form the interlobar and interlobular ducts. In childhood only rudimentary ducts are found and these only partly canalised. By puberty these same ducts, fully canalised, and the nipple are evident. Not until menstruation is established do the intralobular ductules develop from the sides of the interlobular ducts, and the alveoli from these. (Witch's milk, the secretion from the breasts of newborn infants which is occasionally met with, is the secretion from the duct lining of the interlobar and interlobular ducts. The stimulus to such secretion is the high œstrogen level in the fœtus acquired from the mother's blood. The fall of this œstrogen level may on occasion lead to a shedding of the endometrium and the rare phenomenon of apparent neonatal menstruation).

Following puberty further development in the breast occurs with each menstrual cycle. Soon after menstruation, during the pre-ovulatory phase, under the influence of œstrogens, the duct tissue starts to proliferate. After ovulation, in response to progesterone, the intralobular ductules and the alveoli develop. In turn, each month, there follows a short period of regression, but until full virgin development is reached each month shows a slight positive balance in favour of maturation above the base line from which the breast started at the beginning of that particular cycle. Œstrogen alone can produce only duct and stromal proliferation, and although in many animals lactation can be made to follow the artificial development of the breast with œstrogen, such milk, which is of normal quality and even of commercially significant quantity, is secreted by the epithelium of the interlobar and interlobular ducts, there being no alveoli. Progesterone alone can produce lobule-alveolar growth, and this to any marked degree only following sensitisation with œstrogens. Even with this progress, however, the alveolar elements are but little in evidence until conception occurs.

During the first five months of pregnancy there takes place the final maturation of which the ducts, lobules and alveoli are capable, in response to the high level of œstrogen and progesterone circulating in the blood at that time. In the second half of pregnancy, while bust enlargement may appear to indicate further development, in fact the swelling is due to the accumulation of secretion within the alveolar and duct systems. (It should perhaps be mentioned here that not all authorities accept the view that œstrogen and progesterone act directly on the breast tissue. While some believe that the œstrogen and progesterone incite the anterior lobe of the pituitary gland to produce two hormones, Mammogen I and Mammogen II respectively, which in turn affect the breasts, others consider a pituitary hormone acts by sensitising the mammary tissues to œstrogen and progesterone. The presence of the pituitary is certainly essential to breast development).

LACTATION.

Immediately after delivery, colostrum, only in moderate quantity, is obtainable from the breast until between the second and fourth day (varying in different mothers) when the milk comes in. The exact mode of initiation of this lactogenesis is not clear. The major work on the matter has, for obvious reasons, been carried out on cattle, and the extent to which it can be applied to the human female is uncertain. But the present day view may be expressed as follows :—

During pregnancy the extremely high level of œstrogen in the blood *depresses* the pituitary. During and after labour this level descends until the threshold at which œstrogen *stimulates* the pituitary is reached. The anterior pituitary thus stimulated secretes prolactin which, acting on the alveolar epitheluim, initiates the secretion of milk. (It may be that a distinction should be drawn between *lactogenesis*, which is the initiation of milk secretion and *galactopoiesis*, which is the continued production. In this connection the anterior pituitary adrenotrophin, causing an increased secretion of adrenal cortical hormones, has been found to be of importance. The significance of these latter probably lies in their relation to the supply of milk precursors rather than to any direct specific effect on the glandular epithelium. There is good evidence to suggest that the stimulus provided by the child at the nipple causes the anterior pituitary to produce this adrenotrophic factor).

SUCKLING.

It has long been felt that it was erroneous to imagine that the baby could empty the breasts by the simple expedient of producing a negative pressure in its mouth and pharynx, thereby withdrawing milk from the depths of the gland—namely, sucking. The force of capillary attraction and the collapse of the duct walls would surely make such a task impossible.

In cattle, at milking time or at the commencement of milking, the pressure in the cisterns behind the teats suddenly rises and this, known as the " let down " is the result of extrusion or forcing forward of the milk from the deeper glandular recesses to the more superficial and capacious duct spaces. It can be produced artificially by the injection of posterior pituitary extract (less well by the oxytocic factor alone, and least well by the pressor factor). Not only do the cisterns fill, but the milk is forcibly extruded from the teat. In women a similar condition is recognised and known as " the draught." Certain clinical observations may briefly be recorded here to support the view held that the stimulus to this process is the baby nuzzling and sucking, an afferent impulse travelling by way of the sensory nerves, the cerebral cortex and the hypothalamus to stimulate the posterior lobe of the pituitary gland.

(1) Midwives have, for a long time, to hasten delivery of the placenta, put the newborn baby to the breast at once after delivery, which, presumably by encouraging posterior pituitary secretion, indirectly causes uterine contractions.

(2) Patients, most commonly multiparæ, frequently complain of after-pains only at the time of suckling. Also, while it may not have been proven, it has been widely accepted that breast feeding encourages rapid involution of the uterus.

(3) When a baby is put to one breast in a mother who is lactating freely, milk may often be seen to spurt some distance from the other.

(4) " The draught " can be produced in women by injecting posterior pituitary extract.

After a while this phenomenon, " the draught " or " let down " may occur without the actual stimulus of suckling, as a conditioned reflex when feeding time comes round. The great handicap to this hypothesis, however, has been, and is, the inability of all investigators to show conclusively any muscle capable of forcing the milk forward from the alveoli. Basket cells have been described embracing the gland acini, but so far, unfortunately, no evidence has been produced of their ability to contract. But that the cisterns or sinuses do fill is now accepted and for the baby, to squeeze the milk thence through the nipple into its mouth is at least a task within the bounds of the possible.

It is worthy of note that the " let down " in cows may be completely inhibited by fright. It is not unreasonable to suppose (and experience leads one to believe) that " the draught " in women may similarly be prevented by emotional disturbances interfering with the complex conditioned reflex involved. A cross or impetuous nurse, a cracked nipple or a painfully engorged breast may not only produce tears at feeding time, but may reduce the delivery of milk.

Emptying of the breasts is dependent therefore upon two factors, the first the mother's ability to drive the milk forward to the superficial duct spaces, the second the baby's ability to withdraw it from there. If either fails, then milk accumulates in the alveoli in the depth of the gland. In the early stages of such congestion milk secretion continues and the alveoli become even further distended. If the skin and subcutaneous tissues then lack resiliance the mere enlargement of the deeper elements compresses the ducts and even further difficulty is encountered in moving the milk to the surface. Eventually the back pressure causes a falling off in secretion.

Thus galactopoiesis is affected by the baby in two ways. On the one hand sucking reflexly stimulates the secretion of the galactopoietic factor (possibly the adrenotrophin) of the anterior lobe of the pituitary gland, while on the other it reflexly stimulates the posterior lobe of the pituitary to drive the milk into the sinuses and the infant's reach, and thereby prevents accumulation in the alveoli from mitigating against further milk production.

Practical Applications.

Development.

Marked underdevelopment of the mammæ is so often associated with greater or lesser degrees of hermaphroditism or incorrigible infertility that the indication for encouraging their development is more often psychological (to furnish appearances of a normal anatomy) than anything else. Such patients seldom become pregnant requiring breast development for purposes of lactation. Œstrogen, implanted under the skin, can produce breasts normal to all appearances in a year, where nothing but the chest of a pre-adolescent girl existed before. When the uterus is present, however, there is some risk of considerable hæmorrhage. Attempts at producing breast and nipple growth during pregnancy, where deficiency has appeared to exist, have been unsuccessful, although an inunction of 5 per cent. stilbœstrol in arachis oil, massaged into inverted nipples four to six times daily has some power of producing eversion if carried out for a month before term.

Lactation.

Galactopoiesis. Various attempts have been made to encourage the secretion of milk. Anterior Pituitary Extract, on physiological grounds, is the obvious choice. This has met with some success, increasing the milk yield by as much as 16 per cent. overall during and after treatment. But whereas some patients react well, others fail to respond at all, and necessitating repeated injections and considerable expense, as it does, for so small an increase, it has little to recommend it.

Thyroid (8 grains per diem) and Thyroxine (1.6 mgm. per diem) have both been used. Some results have been encouraging, showing an increase in yield of 25 per cent. during

medication, and 19 per cent. overall. This has the advantage of being active when taken by mouth, but almost certainly acts by stimulating body metabolism generally and this must clearly detract from its appeal. Iodine given as 6 drops of Lugol's solution b.d. has also produced some encouraging results.

Œstrogens are probably the most useful endocrine preparations in lactation. The aim of their use is to diminish the congestion so common when the milk first comes in, which is so commonly, as a result of the back pressure it produces, a precursor of failing lactation. It is in fact, indirectly rather than directly, a galactopoietic. Which œstrogen should be used is determined only by considerations of expense and facility of administration. Stilbœstrol by mouth is as good as any. To judge when it should be given and how much should be given requires experience if maximal good and no harm is to accrue from it. 5 mgms. taken if the breasts cause discomfort on or about the third evening and similar or smaller doses after each feed until a free flow of milk and relief from the discomfort is achieved, is a sound plan.

At the same time, if there is a noticeable failure of the milk to come forward to the sinuses, 10 units of pituitrin injected at the start of a feed may have the desired effect.

Œstrogens may also be given for lactorrhœa, in which the milk runs from the breast at all times. This not only wastes the secretion which should be held in store for feed times, but produces soggy softened nipples with little resistance to suckling. Stilbœstrol should be exhibited after feeds for five to seven days.

Inhibition. Finally, there is probably no more useful application of endocrines in this field than in the inhibition of lactation. Whereas but a little while ago tight binders, purging and deprivation of fluids were required, and even then the discomfort was considerable, now lactation can be painlessly inhibited with almost certain success, by œstrogens. Pregnant and puerperal women tolerate large doses of stilbœstrol, such as would cause marked toxic symptoms in the non-pregnant. 5 mgms. of stilbœstrol t.d.s. on the first day, 4 mgms. t.d.s. on the second, 3 mgms. t.d.s. on the third, 2 mgms. t.d.s. on the fourth and 1 mgm. t.d.s. thereafter for four days is a good régime. It acts by depressing the activity of the anterior lobe of the pituitary, but to this extent and for this duration, it is quite harmless.

Guy's Diary

ACADEMIC

JULY.

Exhibition. Surgical Department. "Diseases of the Hip."

4th. 12.00. Surgical Staff Conference. Clinical Theatre.
1.00. Dr. McArdle. Clinical Lecture. "The Treatment of Migraine and Unilateral Headache."
3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

5th. 1.00. Mr. Atkins. Clinical Lecture. "The Royal College of Surgeons."
2.15. Dr. Marion B. Sulzberger (Professor of Dermatology and Syphilology, the New York Skin and Cancer Unit) and Dr. L. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

7th. 4.30. X-ray Demonstration. Gordon Museum.

9th. 10.00. Mr. R. C. Brock. Surgical Departmental Round. Clinical Theatre.

11th. 3.30. Demonstration of Skin Diseases. Preclinical Classroom.

12th. 12.00. Sir Charles Symonds. Neurological Demonstration. Preclinical Classroom.

14th. 1.00. Mr. Wass. Clinical Lecture.
4.30. X-ray Meeting. Gordon Museum.

15th. 1.00. Dr. Kauntze. Clinical Lecture. "Bronchial Carcinoma."

18th. 1.00. Dr. Boland. Clinical Lecture.
3.30. Demonstration of Skin Diseases. Preclinical Classroom.

SPORT

JULY.

6th. 11.30. 1st XI. *v.* Addiscombe (Away).

9th. 12.00. 1st XI. *v.* Three Counties Hospital (Away).

10th. 2.00. 1st XI. *v.* Nomads (H.O.P.).

16th. 2.30. 1st XI. *v.* Private Banks (Away).

17th. 11.30. 1st XI. *v.* Buccaneers (H.O.P.).

The Steele Diaries—VIII

THE HOSPITAL

8th April, 1857.

I have again to call your attention to the constantly recurring nuisance produced by the stench from the Chemical Laboratory. Yesterday afternoon the Matron's House, Library, and these offices were rendered perfectly uninhabitable.

26th August, 1857.

Great annoyance has been felt in Petersham Ward during the past week in consequence of the discovery of a colony of Bugs which have attached themselves to the beds and wooden skirtings of the ward. The evil has been mitigated by the removal of the curtains and the changing of the bedclothes, but it will be impossible to extirpate the vermin until the ward is emptied and the bedsteads repainted.

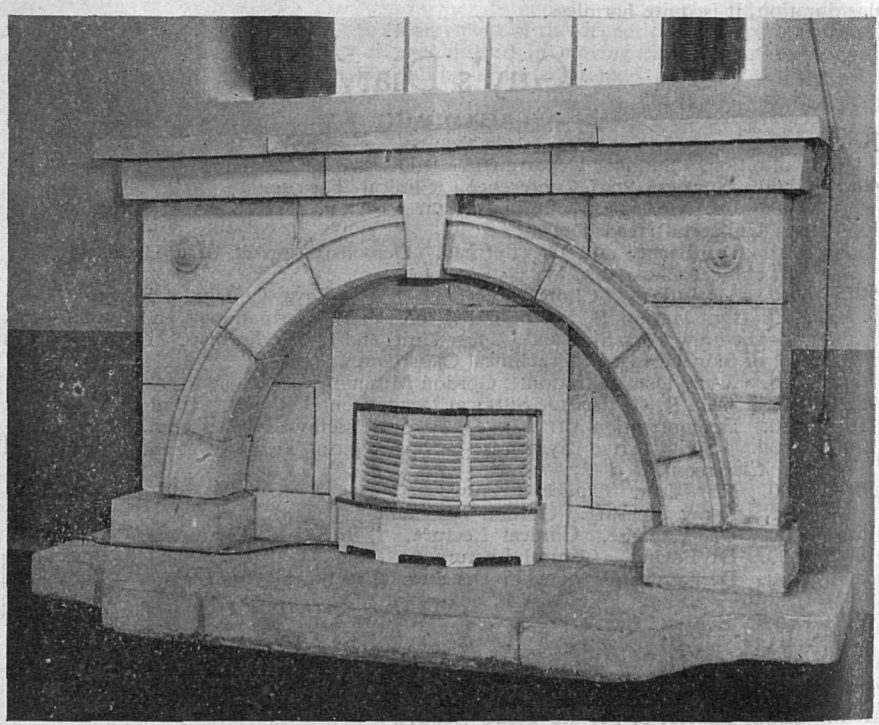
2nd September, 1857.

In connection with a passage in last week's report, referring to the bugs in Petersham Ward, I regret to state, that on further investigation the nuisance appears to be general in those wards that have not undergone the necessary clearance and cleaning, especially in Mary and Dorcas Wards. Measures are being taken to remedy the evil and in the New Building it has been found necessary to unscrew all the medicine shelves over the respective beds, and also to repaint and putty the wooden ledges to which the bedsteads are attached.

26th May, 1858.

A wish was expressed by Mr. Biddulph (Governor) at the last weekly meeting, that a notice in the form of a handbill should be printed giving the days on which the out-patients are seen, the particular class of cases that are seen on their respective days and the rota of the Medical Officers in attendance. It occasionally happens that patients are sent by the Governors to the Out-patient Department, on days when it is not usual to examine them for these particular complaints.

(*continued on page 211*)



The Fireplace in the New Smoking Room.

Lord Nuffield and Guy's

IT was a fortunate day for Guy's when the late Sir William Hale-White became a member of the Huntercombe Golf Club for in the latter nineteen-twenties he was instrumental, either directly or indirectly, in introducing to the Club a number of exceptionally keen Guy's men, then in the flush of youth or early middle age and now, alas, toning down quietly into the "sere and yellow." About that time Lord Nuffield had become the owner of the Huntercombe Estate, which included the Golf Club, and he lived then, as he does now, in the immediate vicinity of the Clubhouse. These circumstances provided the opportunity for him to come into intimate social contact with many members of the Guy's staff, for over a period of many years there was rarely a week-end when there was not a Guy's party staying in the Clubhouse, especially at Christmas, Easter and Whitsun, and Christmas Dinner at Huntercombe with Lord and Lady Nuffield as the hosts was always a merry and joyous affair. As his Lordship had always been interested in Medicine—indeed he has frequently confessed to a hankering after a medical career in his early manhood—it was not surprising that, when the need arose in connection with the health of any of his senior staff, he sought the advice of his Guy's friends. In this way he became familiar with the Hospital and with the facilities then available in Bright Ward and he was not slow to appreciate that an enlarged Bright Ward would meet a very real and crying need. After due deliberation—for his countless benefactions have never been made on the impulse of the moment—he informed the Court of Governors that he wished to erect at Guy's a separate block for private patients in which special facilities should be extended to those of "moderate means." His offer was gratefully accepted and the outcome was "Nuffield House," built in 1935 at a cost of £73,000, and originally it provided 72 beds of which 20 were arranged in cubicles to meet the wishes of the donor.

Invited to become a member of the Court of Governors in 1934, his Lordship was unanimously elected to the Office of Treasurer in the following year when the late Mr. F. P. Whitbread resigned. In view of the many claims on his time and because he felt that he should not undertake duties which he might not be able to perform, he asked that a deputy should be appointed to act as the Chairman of the Court. This request was readily conceded, and Lord Cunliffe was appointed to the new office. But Lord Nuffield was a regular attender at the Court and frequently visited the Hospital at other times when, often under the guidance of the Matron (then Miss E. P. MacManus), he acquired a first-hand knowledge of the importance of good nursing in a hospital of standing and repute. At that time the accommodation in the Henrietta Raphael Nurses' Home could no longer cope with the growing number of nurses on the establishment, and as a temporary measure, quarters had been found for the night nurses in a hotel in Lancaster Gate. As soon as he realised the additional strain and inconvenience to which these nurses were subjected, Lord Nuffield informed the Court that he wished to provide an extension to the nurses' home so as to enable all the nurses on the establishment to be housed within the Hospital precincts. Advantage was taken of the opportunity to make additional provision for comfortable sitting and recreation rooms, to modify the kitchen and service arrangements, and to extend the sickroom. The Nuffield Nurses' Home, which cost rather more than £80,000, was built in 1939–40, but owing to the war no adequate opening ceremony was possible and, as opportunity offered or as circumstances demanded, the new Home was gradually brought into use, and now everyone of its additional 140 bedrooms is in occupation.

It should be remembered that, although Lord Nuffield's earlier benefactions had usually taken the form of gifts to individual hospitals, his outlook had steadily widened and the establishment of the Nuffield Medical Trust, the Nuffield Trust for Provincial Hospitals, and the Nuffield Trust for the Distressed Areas was followed in 1942 by the greatest benefaction of them all, the establishment of the Nuffield Foundation, which, with a capital of some twelve million pounds, is the largest charitable gift in the history of this country and incomparably the finest conception for the benefit of mankind. Nevertheless, when the damage suffered by Guy's during the German air raids on London made it increasingly clear that a great scheme of rebuilding would be forced on the Governors, Lord Nuffield personally arranged—with the ready concurrence of the King's Fund, to which, in accordance with his original plan, all repayments for the Distressed Areas' Trust accrued—that a sum of £250,000 should be given to the

Rebuilding Fund. In cash value, this is the largest gift that the Hospital has ever received and indeed exceeds the total amount of the original endowment.

But his Lordship's interest in the Hospital is exemplified in other ways than these. The writer remembers vividly the Christmas of 1937 when London was wrapt in a thick, almost impenetrable, fog. Lord and Lady Nuffield had promised to visit the Wards on Christmas morning, and they were not deterred. They motored the forty odd miles from Huntercombe, made a tour of the Wards by artificial light and, after lunch, drove off into a thick fog in convoy with two Guy's cars whose drivers were more familiar with the London end of the route.

Lord Nuffield always made a point of attending the Governors and Staff Dinners while he was Treasurer of the Hospital and, although he invariably insisted that he should be excused from making a speech, members of the staff will remember that, when the time came, he felt it almost a duty to rise and express his admiration for the work of the Hospital and to indicate the pleasure that he derived from his association with it. All who heard them will recall the note of sincerity that pervaded these speeches. Obviously impromptu, they came straight from the heart, and won him many friends amongst his hearers.

And so, when Lord Goschen informed the Court in 1944 that he felt that the time had come for him to resign from the Office of President, Lord Nuffield was unanimously elected to succeed him and held office until July 5th, 1948. On that date, the material part of the Hospital passed into the possession of the Ministry of Health under the National Health Service Act, but the spiritual part remained in the possession of all Guy's men and women, and, when the formal difficulties had been overcome, Lord Nuffield was unanimously elected by the new Board of Governors as the Honorary President of the Hospital.

When Lord Nuffield became our President, the late Mr. John E. Humphery succeeded him as Treasurer. Mr. Humphery had the greatest personal regard and an unbounded admiration for Lord Nuffield and he was anxious that his incomparable generosity should receive some very special mark of recognition. And so, after much discussion as to the form which this should take, it was resolved by the Court in August, 1944, that a statue of his Lordship should be put up in the Hospital precincts, the cost to be defrayed by private subscription. No attempt was made to publicise the project, but as the result of the response made by the Governors, the Staff and many old Guy's men and women, no difficulty was experienced in meeting the cost. For nearly two hundred years the statue of Thomas Guy has looked down beneficently and reassuringly on all who entered by the gates of the Hospital and when the "brave new" Guy's at long last raises its lofty head to look out over the ancient Borough of Southwark, its entrance will be flanked by the statues of those two humane benefactors who freely gave the wealth that they had acquired by their industry, integrity and disregard of self for the benefit of their fellow men.

(*see opposite page.*)

This statue of **the Rt. Hon. Viscount Nuffield, G.B.E., F.R.S., M.A., D.C.L.** was unveiled by the Rt. Hon. Viscount Goschen, P.C., G.C.S.I., G.C.I.E., on Wednesday, June 29th, 1949. Standing in the West Quadrangle of Guy's House, beside the Colonnade, it was executed by Mr. Maurice Lambert, A.R.A., amongst whose many works are busts of Sir Lionel Earle, the Gaekwar of Baroda, and the Maharanee of Cooch Behar. He is represented in the Chantrey Bequest and the Tate Gallery. At the outbreak of war he was engaged upon an equestrian statue of King George V, commissioned by the Australian Government, for Adelaide. On September 2nd, 1939, he joined the Royal Welch Fusiliers and was invalided out of the army in 1943, when he was a Captain in the Parachute Regiment. Between then and September, 1944, when he returned to his profession, he went to work in a shipyard.

The plinth on which the statue stands is the work of Mr. Edward Maufe, R.A. Architect.

Topical Press

GUY'S] HOSPITAL] AMATEUR BOXING CLUB.
WINNERS OF THE INTER-HOSPITALS CHAMPIONSHIPS, 1948–1949.

(Trainer). Matt Wells. D. M. Griffith. A. H. Atkinson. P. F. P. Lansdown. A. C. de B. Eksteen. E. D. Sonnenfeld. W. H. Watson.

R. C. C. Thompson. H. N. St. John. A. J. McNair, Esq. W. M. Sheeran. G. A. R. Winston. D. M. Lipington. N. M. Halamandres.
(Vice-Captain). (President). (Captain). (Hon. Tournament Sec.).

(*continued from page 208*)

2nd June, 1858.

I desire, especially to bring under your notice the fact, that notwithstanding the ordinary measures employed, for cleanliness, the Hospital in common with all Buildings of a similar character is more or less infested with bugs, and that unless active measures are taken at present for their destruction great difficulty will be experienced in suppressing them during the hot season.

The plan I wish to suggest is, to place at my disposal a couple of workmen (labourers) to paint the iron joints of the bedsteads, to putty the crevices of the wooden skirtings, and to assist the Flockmen in examining and renewing the canvas sackings throughout the Hospital.

20th October, 1858.

I have also to report the following unpleasant occurrence in the course of the week. On Friday morning the Librarian, Mr. Moore, informed me that his desk had been broken open and a box containing £15 in money had been extracted from it. On examining the small enclosure in the Library we found a pane of glass broken in the adjoining window so as to admit the hand to unfasten a bolt by which the window was secured and the window itself left open sufficiently high to admit a person with difficulty. On the outside wall which is about 8 feet from the ground and which has been recently coloured there was no trace discoverable of an attempt having been made to get in by the window, the dust on the window sill remaining undisturbed although a finger mark might have readily been traced on it. The 3 doors which it would have been necessary to open to obtain entrance to the enclosure from the quadrangle outside were locked as usual. A police detective who examined the premises afterwards concluded that the robbery must have been committed by someone inside well acquainted with the premises.

2nd March, 1859.

I consider it necessary to bring the following case under your notice. It has been suspected of late that a portion of cooked provisions may have been taken at times from the Lunatic Asylum, and on Saturday last the Matron detected one of the servants from the lunatic ward passing out of the Hospital with a basket concealed under her shawl. On examination it was found that the basket contained a bowl full of cooked meat and potatoes and intended for the sister of Mrs. Fitzeler. This person resides in the immediate neighbourhood of the Hospital and besides being in poor circumstances is at present in a very precarious state of health. The servant from the lunatic ward affirms most positively that the contents of the bowl was her own dinner which she was conveying to Mrs. Fitzeler's sister.

29th February, 1860.

The Surgeon of the Eye Wards is very desirous, before he attempts his usual operations on the cases, to know whether the contemplated operations in reference to the removal of the waterclosets can be carried out this season. The offensive smell from an occasional leakage in the closet of Ruth Ward has been frequently complained of and seems beyond the remedy of the plumber.

25th April, 1860.

In consequence of the decision of the College of Surgeons relative to vaccination it may be necessary to have a vaccination station established at the Hospital and one day of the week set apart for instruction in this branch. If this is carried into effect it will seriously interfere with any attempts to introduce the treatment of diseases of children as a separate branch of the out-patient department.

20th June, 1860.

The practice of vaccination will be commenced on Saturday next in the out-patient room and will be continued each succeeding Saturday at 11.30.

18th July, 1860.

Great irregularities continue to occur from the very open state of the railings in the vacant ground adjacent to Hunt's House, and it is feared that many articles are introduced into the Hospital by the friends of patients communicating with them through the railings. It would obviate the evil to some extent if the hoarding place on the railings was made more secure and a notice placed at the entrance intimating that patients found inside the enclosure would be summarily discharged.

26th February, 1862.

I have to report an outbreak of Fever in Philip Ward, apparently originating in the simultaneous occurrences of a case of Glanders and another of Scarlatina which were received into the Hospital about a month ago. The day nurse on duty, who appears to have been particularly attentive to the Glanders case was taken ill 10 days since, being

a week after the death of the patient and about the same time 2 of the patients in the ward were also attacked. Since that time 6 other patients have been seized with Fever and also the night nurse who was in attendance on the Glanders case but who had been transferred to do duty in another ward. Two of the patients thus attacked have died while 4 remain in a critical state. The day nurse first attacked is proceeding favourably but the night nurse is in a very precarious condition. It is proper to notice that no patients affected with ordinary Fever have been admitted to this ward during the past two months and thus none were resident in the ward for some time prior to the present outbreak. The occurrence has created somewhat of a panic among the patients, and it would be advisable to have the ward vacated as soon as possible. With this object, 8 of the patients, not suffering from Fever, could be placed in Mark Ward, now vacant, and 6 more can be accommodated in the vacant beds of Job and Stephen. The combined arrangements for to-day will exclude the admission of male medical and female surgical cases. I may add that I have had occasion during the week to refuse admission to 4 Fever cases.

18*th June*, 1862.

It is proposed by the Treasurer of St. Thomas' Hospital to send the remaining patients in the Hospital to the Wards of Guy's in relays of 12 or 20 cases at a time, in order that the Hospital should be vacated by the end of the month. It will be necessary in taking in patients to-day to make allowance for this arrangement.

25*th June*, 1862.

16 patients, all surgical cases, have been removed from St. Thomas' Hospital to the Surgical Wards during the week.

9*th July*, 1862.

An application has been made to me for a clock for Lydia Ward in consequence of the former one having been removed. The former clock being the property of the deceased Sister whose friends have claimed it.

6*th August*, 1862.

On the evenings of Friday and Monday, the band of the Metropolitan Police performed music for a couple of hours each evening in the airing grounds, and about 200 of the patients were in attendance on each occasion. The effect of the music on the convalescents as well as on those confined to bed has been found most salutary, and it is hailed by the Medical Staff as a valuable auxiliary in therapeutics. It is strongly recommended to be continued at proper intervals.

5*th November*, 1862.

Application is made for a gas jet in Barnabas Ward for the purpose of examining the patients with the aid of the Ophthalmoscope. Great annoyance has been occasioned in Ruth Ward from bugs, and it is suggested with the concurrence of the Surgeons, that the curtains and bed rods and standards might be entirely done away with in this ward.

12*th November*, 1862.

The gas supply to the Clinical Wards has been very deficient during the last few nights evidently from an obstruction in the pipes. For the first time for some years the gas in the operating room was lighted last night but was found to burn very sparingly. As it is likely that the operating room will be used more frequently at night in future, it would be advisable to have the gas pipes seen to, and a couple of reflectors placed on the jets.

4*th March*, 1863.

The body of Wm. Hempfield, bequeathed by himself to the Hospital in 1858, was deposited in the dissecting room last Saturday. A portrait of the deceased was brought to the Hospital at the same time, which he wished to have placed in some Conspicuous Corner of the Hospital.

Yesterday, being the marriage day of the Prince of Wales, the patients, nurses and servants were regaled with Tea, Wine and Cake.

14*th October*, 1863.

An application has been made to me by the widow of the late Ed. Betchley, to permit her to follow her late husband's employment, that of hawking cresses and shrimps in the wards at a given hour daily.

28*th December*, 1864.

On Monday last the patients and servants of the Hospital were supplied with the usual amount of roast beef and pudding, furnished to them at this season. The relaxation of discipline practised on the occasion does not appear to have been attended with any bad effects.

Book Reviews

Surgery—Orthodox and Heterodox. By SIR HENEAGE OGILVIE. Blackwell Scientific Publications. *Price* 12*s.* 6*d.*

Here is a book of twenty-one essays, which for the most part are republished from the *Lancet*, *British Medical Journal*, and *Guy's Hospital Gazette*. Very little of the material is of examination use, although there are some interesting notes on the surgery of the stomach, and war wounds, largely flavoured with an historical essence. Rather are these the ruminations of a surgical craftsman, who enjoys his craft mightily—after dinner gossip under the porch with the apprentice. One is reminded of the picture "The Boyhood of Raleigh." He has not got to the bottom of the business, because he knows there is no bottom. It is good reading, and worth reading.

A Companion in Surgical Studies. By IAN AIRD. 1st Edn. Livingstone. *Price* 63*s.*

This book has one thousand large pages without an illustration or a diagram. Clearly it is for the shelf of the serious student. The author in an introduction which is well worth reading, tells that it is written for the surgical trainee, the graded surgeon and the surgical apprentice, to save him to some extent from the time consuming search for and perusal of origin articles and monographs, and to some extent to guide him to the most momentous of these. It deals with neither fractures nor orthopædics. There are many references. It is the best single book so far produced for the fellowship candidate, and the demand for it should be considerable.

Illustrations of Surgical Treatment. By ERIC FARQUARSON. 3rd Edn. Livingstone. *Price* 25*s.*

This volume describes, for the most part with the aid of profuse photographic illustrations, those treatments in surgery which require not only a definite procedure but a manual technique. There is an early part on intravenous infusion and transfusion, the main bulk on fracture and orthopædic practice, and an appendix illustrating the instruments which (for some reason best known to examiners) one may be shown in examinations. One may grasp with ease from this book that knowledge which takes hours to acquire by reading the laborious verbal descriptions in the standard text books.

H.A.R.

Psycho-analysis. By EDWARD GLOVER. 2nd Edn. Staples Press. *Price* 15*s.*

The would-be student of psycho-analysis has often been hampered in the past by the lack of an epitome of psycho-analytic theory which is at the same time comprehensible and comprehensive. Dr. Glover has endeavoured to meet this need by a brief outline, covering three hundred pages, of the theoretical and clinical aspects of psycho-analysis, with a note on its practical applications. A section is devoted to the psychosomatic disorders, which the student of medicine may find to be insufficiently physiological in its presentation. There is little mention made of the large volume of research work in psychophysical relations which has appeared during the last ten years. The basic concepts of Freudian doctrine are however set out with lucidity and conciseness, and the scope and limitations of analytic psychotherapy clearly stated.

D. O'N.

Psychological Aspects of Clinical Medicine. By S. BARTON HALL. 1st Edn. H. K. Lewis. *Price* 21*s.*

In this book the Consulting Psychiatrist to the Liverpool Royal Infirmary has set out the content of a special course of instruction given to senior medical students on the place of psychiatry in general medicine. The clinical material from which illustrations are drawn is that of the psychiatric out-patient department and the general hospital ward; the emphasis is less upon delimitation of disease types than upon methods of approach. The field includes: technique of examination, intellectual and emotional development, psychological symptoms in physical disease, psychosomatic relationships, physical basis of abnormal behaviour, and differential diagnosis. The book supplies a strongly felt need; it is an excellent basis for teaching in a fundamentally important aspect of medicine.

D.O'N.

The Sulphonamides in General Practice. By EDWARD D. HOARE. 1st Edn. Staples Press. *Price 5s.*

This book is well worth five shillings. It tells you all you could want to know about the subject, and not so very much more. You can read it in an hour and a half, and see what is used for what and when : and, of course, forget most of it : but know where to refurbish your mind with knowledge when you want to use the Sulpha drugs.

C.H.R.

Also received.

Aids to Materia Medica for Nurses. By AMY SQUIBBS. 3rd Edn. Bailliere, Tindall & Cox. *Price 5s.*

The Exhibition of Art

AN exhibition of works of art by amateurs obviously differs essentially from one arranged by a group of professional artists or regular students. They are not people who draw or paint so much because it is their business, but rather people who, with all the other calls on their time, yet feel impelled to say something important or express some taste, taking line or colour as their medium. The consequence is that an exhibition of this sort is apt to contain a much higher proportion of works of genuinely personal vision than some professional exhibitions. Trained artists may cavil at technique or lack of it. Moreover there is place in an amateur exhibition for exercises in accepted styles, made for sheer pleasure in imitative craftsmanship, which would be inappropriate in a professional exhibition. Of course one expects to find amateur artists clothing their visual experiences or ideas under forms borrowed from the work of contemporary or older masters whom they admire. But that is not the significant point. The important point is what they see and manage to express, not how they do it. All this makes an exhibition like this one exciting and stimulating for the spectator. And when an exhibition is organised inside a society like Guy's it may perhaps, as well, have a peculiar fascination for the exhibitors too. Suddenly to see, alongside one's own, the work of a colleague whom one never even suspected of painting or drawing, must bring its surprises. If it will lead to more exhibitions as interesting and fresh as this, one must hope that the idea of establishing a regular sketch club at Guy's will be taken up, and the club flourish.

There is hardly a work in this exhibition which does not strike a clearly personal note. What follows cannot be more than an arbitrary florilegium. Nobody could fail to be impressed by the work of R. Anderson, which shows his experimenting hand serving a percipient eye. His "Old Philosopher" stands out as a penetrating character-study. J. C. Jellyman's "Study of a Gypsy Boy," by comparison, succeeds in making a quite individual and sensitive portrait which is at the same time academic. J. C. Matthews' drawings authentically re-evoke the damp heat and intense colour of what he saw in Burma. W. N. Mann's view of Arles has a personal quality which transcends his evident study of van Gogh. A feeling for the surface-texture of rough grey paper, no less than a kinship with Chinese art, underlie C. H. Kinder's felicitously composed drawing of two ducks.

Private tastes cannot be suppressed. Among the things we especially enjoyed and should delight to have on our walls are E. S. Rose's "Otter Point." Mary Vick's "View from Eire," "Siamese Kittens" by P. R. Evans, R. Colne's "Cottage," Alan Parkes' "Thames Barges," R. MacKeith's watercolour of Cap Bon and D. Swindells' "View from my Window." . . . The list lengthens inevitably as we recall the exhibits one by one. But it cannot conclude without mention of a work of surely exceptional distinction—Philip Reading's "Post Mortem."

As the outside visitor leaves this exhibition, and sees in a case nearby, the memorials of Keats and, in the next room, the models of Joseph Towne, he can hardly escape wider reflections. Towne exhibited in his day no less than fourteen sculptures in the Royal Academy, and a dresser from Guy's was a poet of perhaps intenser genius than any in English letters. Who knows what painter the same place may still harbour?

L.D.E.
C.M.

Sport

CRICKET

Guy's *v.* Bognor Regis

at Bognor. Result—Won.
26th June, 1949.

As usual Pat Russell was remarkably good humoured when he found the team two short, but Woodford who had somehow joined an excursion and was all but swept on to the beach and Meyer who entered the hurly-burly of London Transport and was dreadfully delayed, finally arrived.

And Guy's batted and it was Blake's day. He scored such an admirable 93 that even numbers 10 and 11, who positively pray that the boys will get out, grudgingly commended him. Rather overshadowed before lunch, Russell after lunch quite suddenly was 50 and then proceeded to distribute the bowling to the outfield and scamper to 92 when, to the spectators surprise and his own subsequent horror, he declared. Guy's 244 for 6.

At tea Bognor were 88 for 3 and Bill Tweed had neither batted nor bowled. Nevertheless he had run from gully to the boundary and, in his zeal, had saved the 4, tripped headlong over the rope (to the almost Roman delight of the crowd), picked the ball up and hurled it in while the batsmen ran four behind his back.

After tea, however, he bowled and indeed he bowled well. He took two quick wickets and immediately afterwards an easy, nay an elementary, catch was dropped at mid-off, and almost at once another easy catch went to poor Pat Martin.

Now Martin is not a bad fielder, he stoops to pick up the ball with quiet dignity like a bishop confirming black children; he uses his extended foot judiciously (though he has been seen to tread on the new ball a little heavily), and all the while on his face is the spiritual peace of the monastery. But alas! for human frailty, this time he erred and the ball fell heavily to the ground. Tempering justice with mercy, Russell sent him to deep extra cover (he might well have been sent to 3rd man or even, for his offence was grave, to perpetual fine leg).

Tweed, however, battling against the opposing batsmen and his own fielders took 6 for about 20 and Bognor were all not for 140 odd.

TENNIS CLUB

Semi-Final of United Hospitals Cup

Guy's *v.* Westminster

at H.O.P. Result—Lost 8—7.
Saturday, June 18th.

After a very easy match against University College Hospital which we won 12—0, Guy's were matched in the semi-final of the tournament against much tougher opponents—Westminster Hospital.

Westminster are extremely strong this year in that N. R. Lewis, reserve member for the British Davis Cup team, is now one of their students and in addition they have D. H. Mackenzie, present holder of the United Hospitals' singles cup.

It was generally accepted that this would be one of the key matches of the tournament and such it proved to be. Certainly we had a most enjoyable day's tennis and our small band of somewhat silent supporters apparently appreciated to the full the effort and energy expended on the courts.

Unfortunately the ability of our opponents, plus a slight psychological advantage, just tipped the balance and Guy's were narrowly beaten 8—7.

The scores were as follows :—

Singles :

E. G. Searle lost to M. R. Lewis, 6—0, 6—1.
C. H. Opie lost to D. H. Mackenzie 7—5, 6—2.
F. A. F. Biddle beat J. Goodman 9—7, 6—3.
L. Mackey lost to R. Grande 6—3, 6—4.
J. Annen beat P. Lowe 6—4, 4—6, 6—4.
P. Hirsch beat C. Cox 7—5, 4—6, 6—2.

Doubles :

Searle and Biddle lost to Lewis and Lowe 6—2, 2—6, 6—2; beat Mackenzie and Grande 6—4, 6—3; beat Cox and Goodman 6—2, 6—2.

Opie and Annen lost to Mackenzie and Grande 6—1, 6—8, 6—4; beat Lewis and Lowe 8—6, 4—6, 6—4; beat Cox and Goodman 6—2, 6—1.

Macken and Hirsch lost to Cox and Goodman 7—5, 3—6, 6—2; lost to Mackenzie and Grande 6—3, 6—3; lost to Lewis and Lowe 6—1, 6—3.

It is sad that the Cup should be leaving Guy's this year but we look forward to 1950 when we must make sure that it comes back to us.

E.G.S.

SAILING CLUB

Hayling Island S.C., whose club-house stands at the entrance to Chichester Harbour, were at home to a United Hospitals S.C. team on June 11th and 12th. There were two team races, both held in 12 Square Metre Sharpies, one of which, "Thomas Guy," is the property of the Guy's Commodore. On Saturday, United Hospitals including I. Bradbeer and D. B. Longmore from Guy's, won by 10½ pts. to 9 pts. Hayling Island won on Sunday by 9½ pts. to 9; resulting in a win for U.H.S.C. by 19½ pts. to 18½. The weather, and hospitality of the Hayling Island club can only be described as superb.

The fourth Inter-Hospital race at Burnham this season was won by St. Mary's, Guy's 2nd, London 3rd, and Royal Dental 4th. St. Thomas's were disqualified after a protest from the London. The U.C.H. boat retired.

Hospital Information, etc.

NOTICES

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the post of Half-time Assistant in the Department of Preventive Dentistry to commence duties on 1st October, 1949. Minimum salary £500 per annum plus superannuation and family allowance. Forms of application are obtainable from the Dean, Guy's Hospital Dental School, London, S.E.1, to whom applications with the names of three referees should be sent not later than 1st September, 1949.

PASS LIST

ROYAL COLLEGE OF SURGEONS OF ENGLAND

FINAL EXAMINATION.

F.R.C.S.

June, 1949.

A. G. A. Albers — R. T. Hinde
H. L. Brunow — H. P. Jones
P. B. Counsell — P. A. L. Roberts
I. D. Henderson — John Wilks

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Fellow.

K. M. K. Duff

Member.

B. C. M. Reed

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

March, 1949.

Pathology, Bacteriology and Forensic Medicine.

A. R. Davis

Medicine.

H. E. G. Dyer — D. F. Potter
Q. F. Neethling — H. V. White

Midwifery.

A. R. Davis

CONJOINT BOARD

M.R.C.S., L.R.C.P.

Chemistry, Physics and Elementary Biology.

J. H. Aust — E. G. Lewis
M. D. Awty — D. Lindsey
D. J. Baynon — D. M. Middleditch
J. E. Blinkhorn — H. D. O. Osmond-Smith
J. M. Cautley — G. Pearson
N. J. S. Hills — W. Sims
W. J. Howells — P. G. Willis

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F. W. Antscherl — S. A. Lewis
H. F. A. Baker — J. F. Pike
J. C. Cranfield — M. A. Webber
G. H. Daw — K. P. R. Wellham
H. A. Hill

Diploma in Anæsthetics.

F. W. Chippindale — B. G. P. Oakenfull

Diploma in Physical Medicine.
Part I.—Dr. E. J. Crisp.

APPOINTMENTS

UNIVERSITY OF LONDON

Mr. G. A. D. Haslewood, D.Sc., has been appointed to the University Chair of Biochemistry at Guy's Hospital Medical School from October 1st, 1949.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

At a meeting held on June 9th, 1949, the following were co-opted to the Council:—

Mr. A. D. Marston (*Anæsthetics*).
Prof. R. V. Bradlaw (*Dental Surgery*).

EXAMINERS.

Fellowship.

Anatomy.—Prof. James Whillis.

Applied Physiology and Pathology.—Prof. W. R. Spurrell.

Diploma of L.R.C.P., M.R.C.S.

Pathology.—Mr. Lennox Broster.

BIRTHDAY HONOURS

O.B.E. (Military).

Surg. Commander William Vincent Beach, F.R.C.S.E., R.N.

O.B.E. (Civil).

Albert William John Craft, M.R.C.S.

The film, "A Case of Rheumatic Chorea," made by the Wellcome Film Unit for Dr. Ronald MacKeith, has been selected to be sent to the International Film Festival, at Venice, next month.

EDS. { H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

WE publish, in the correspondence columns of this issue, some very heartfelt criticism from a Guy's man of considerable long standing. We have also recently exchanged letters with another of even older vintage (he qualified in '96), complaining for the same reason, namely, that there was insufficient space given in the *Gazette* to reports on sporting fixtures. Whereas we realise that we cannot please all of our readers all of the time, we endeavour to please as many as we can most of the time and we regret that in these cases their hospital journal is clearly not what they would have it be.

While being by no means in sympathy with some of the reasons that Dr. Wacher gives for including more detailed accounts of these events, we can appreciate the pleasure it must give to him and his contemporaries to read of the athletic successes and struggles of their old hospital. Towards gaining an improvement in the reporting of these activities, Dr. Wacher's letter should go a long way, if only it is read in the right places. Within the last year, since the slight increase in paper allotment occurred, no matter sent to us for the columns concerned has been turned down, and on many occasions applications have gone out from these offices to club captains and secretaries for more punctual and regular contributions. The response has never been remarkable and seldom long lived. (We do not know whether it has ever been the practice for the editorial staff to undertake its own reporting on these matters. They certainly do not consider it practicable now). We can only hope that those gentlemen who exert themselves for the benefit of their colleagues, by undertaking the often thankless tasks entailed in being club officials, will see fit and find time to exert themselves even further for the benefit of those Guy's men of older generations who like to follow their successors, if not on the playing fields, then at least in print. We might add here, that perhaps many more would in fact follow them from the touch line and the pavilion if given the opportunity. Neither the first round cricket cup match against St. Bart's, nor the replay, was advertised in the Guy's Diary. The latter match was unfortunately not fixed as to date and time until the last issue of the *Gazette* had left the printers. That is some sort of an excuse. But surely Guy's cup matches belong not only to the generation of Guy's men at present in the hospital, those men who are able to see the notice boards and hear the gossip, but to others who have fledged and flown. Surely arrangements could have been made and decision taken sufficiently far in advance for them to have been suitably publicised. The same state of affairs, we gather, is about to occur again. Guy's, after a spirited match, beat St. Bartholomew's Hospital last Monday. On the evening of that day we requested that we might be given the time, date and place of the semi-final to be played against St. Mary's for inclusion in this issue. We were told that whereas it will not be fixed in time for that, it will have been played, in all probability, before the coming issue in a fortnight's time. We do not of necessity lay the blame within these walls, but it is, to say the least of it, an unhappy state of affairs.

A British Medical Student Publication recently received, reporting a Conference of Editors of Medical Student Magazines, observed firstly that the *Gazette* is the only such magazine which may be considered a scientific journal, and secondly that it alone of all the hospital Magazines in this country is published sufficiently frequently and regularly to carry " hot news."

Our circulation per issue has recently passed the four thousand mark. Let us take this not only as a measure of the *Gazette's* successful past, but as an indication of its continued responsibility at the present and in the future.

Timing in Surgery and Accident Services

WITH A NOTE ON THE GEOGRAPHICAL DISTRIBUTION OF DOCTORS REFERRING PATIENTS TO GUY'S.

By PATRICK CLARKSON.

AN investigation was conducted in December 1948, to find out exactly how long patients were spending in the Front Surgery for their examination, primary treatment and disposal. Not much exact information was known on this subject. There was the general impression that the great majority spent less than two hours in the Surgery, and that if a patient spent more than four hours there this was often due to something avoidable. It was hoped that the investigation would help to make it possible to set standards of time within which certain groups of patients should receive their full attention, and that it might also show how the present staff in the Surgery could be best allocated, or augmented.

Time is only one of the facts, certainly not the most important, which determine the efficiency of Surgery services. But one effect of such an investigation is to concentrate the attention of all on the need for promptness in attention to patients. Certainly when Dressers, Out-Patient Officer (O.P.O.), Casualty Surgeon and others have to indicate and sign on a sheet of paper the exact time at which the patient is seen and treated this acts as an encouragement to promptness.

For the purpose of this investigation every patient on admission to the Surgery was issued with a pink card. On this card was written such information as time of arrival, time seen by Dresser, time seen by O.P.O., time for different aspects of treatment, time for different aspects of X-ray, time for different aspects of the Take-In House Officer's attendance, and finally the total time spent in the Surgery. Just under 1,500 cards were completed in three weeks. It was thought that any less comprehensive investigation would be open to serious errors in interpretation, as both the number of staff and the rate of entry of patients varies widely at different periods of the day and night. The graph previously published (I) is reproduced here to illustrate that patients come to the Surgery in three main waves—between 9 a.m. and 10.30 a.m., between 1 and 2,30 p.m., and between 6 and 8 p.m. The morning intake is the largest, the evening the the smallest. The staff on duty varies, too. After 7 p.m. there are only one A.H.S. and two Dressers as compared to three Dressers, two O.P.O.s and the Casualty Surgeon between 9 a.m. and 7 p.m. The night nursing staff of three is less than half that on day duty.

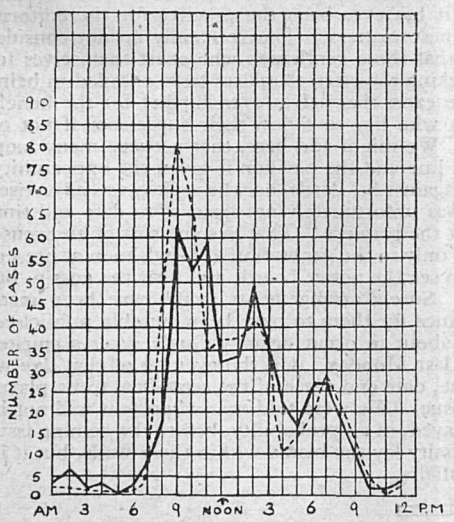


Fig. I. — Graph to show times at which patients come to the Surgery (average times for two weeks in November, 1947, plotted).

Types of Case.

The two chief types of case seen at the Front Surgery are the acute Sick and the Accidents. These two groups were for the most part analysed separately. The majority of cases are ambulatory and suffering from minor accidents or illnesses without severe symptoms, but a certain proportion—multiple injuries, cases of poisoning—are gravely ill and may need, in addition to diagnosis and disposal, some urgent treatment in the Surgery. For a large number of Surgery patients an anæsthetic for the reduction of a fracture or the drainage of a hand infection has to be given.

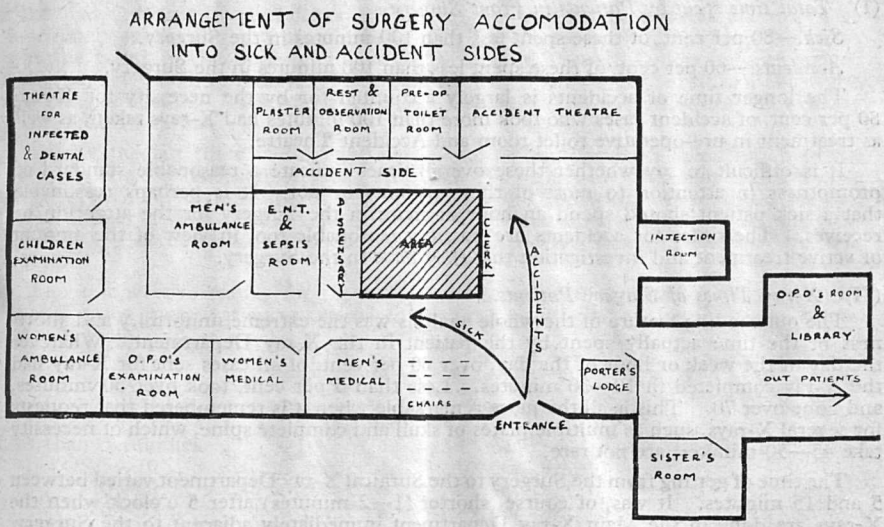


Fig. II —Plan to show the Surgery space within which the events timed and reported here take place.

Routine.

Before discussing the results of this analysis the following brief review of what happens to the majority of patients in the Surgery must be given. If ambulatory he or she enters and sits in the hall. The nurse asks if he is sick or if he has injured himself; the patient is then directed to the appropriate side of the Surgery and given the corresponding white or blue card for his case record. His temperature is taken and this and his personal particulars are entered on the card and Surgery books. He then waits until he sees a Dresser who takes and writes the history and examines him. The Dresser has then to call the O.P.O. who, after his own examination, may decide that an X-ray is necessary; in this case the form is completed, and the patient either walks or is transported to the X-ray Department. On return to the Surgery he awaits the return of the X-ray plate and for its examination by the O.P.O. This may be accompanied by consultation with the other O.P.O. or the Casualty Surgeon or the X-ray Department. Treatment (in accident cases) is then started. This may comprise a twenty minute toilet of the hand and then a full-dress repair in the theatre under local anæsthesia. The patient, whether suffering from an accident or superficial surgical sepsis, will then go to the Injection Room for A.T.S. and penicillin. He returns after this to the desk of the duty clerk for his final hospital documentation. The " Sick " after examination by the Dresser and O.P.O. and possibly an X-ray, are given an appointment to attend the appropriate Out-Patient Department, or a letter is written to their doctor.

Cases thought by the O.P.O. to need admission to the wards are, of course, held in the Surgery until seen by the Take-In House Officer who decides whether to admit them to Guy's or make arrangements through the E.B.S. or other agency for their admission to another hospital, or their return home.

Before this investigation started it was known that the common bottle-necks in this sequence of events were :—

1. The relative shortage of O.P.O.s because of the demands on his time—to examine all children, supervise or do operations, see X-ray plates and examine ambulance and letter cases (including the intensive treatment of such emergencies as acute poisonings).
2. Shortage of theatre space for the accident cases so that a queue often forms of cases awaiting operation.
3. The time needed to complete an X-ray investigation.

The following are the results of the consolidation and analysis of these cards :—

(I) *Total time spent by Patients in Front Surgery.*

Sick.—80 per cent. of these spent less than 100 minutes in the Surgery.

Accidents.—60 per cent. of these spent less than 100 minutes in the Surgery.

The longer time of accidents is largely accounted for by the necessity for X-ray: 80 per cent. of accident cases who took more than 100 minutes had X-rays taken, as well as treatment in pre-operative toilet room and Accident Theatre.

It is difficult to say whether these overall times indicate a reasonable standard of promptness in attention to most of these patients or not. It is perhaps reasonable that a sick patient should spend an hour or more in the Surgery for the attention he receives. The times for accidents are possibly reasonable too, in view of the amount of active treatment and investigation that they have in the Surgery.

(II) *X-ray Times of Surgery Patients.*

The outstanding feature of the whole analysis was the extreme uniformity and shortness of the time actually spent by the patient in the X-ray Department. Whatever the day of the week or hour of the day, over 80 per cent. of all cases sent for X-ray had the X-ray completed in 10—30 minutes. Less than 5 per cent. took over 50 minutes, and none over 70. This is all the more remarkable when it is remembered that requests for several X-rays, such as multiple plates of skull and complete spine, which of necessity take 45—50 minutes, are not rare.

The time of getting from the Surgery to the Surgical X-ray Department varied between 5 and 15 minutes. It was, of course, shorter (1—2 minutes) after 5 o'clock when the X-rays are done in the Main X-ray Department immediately adjacent to the Surgery. When all X-rays are done there the work in the Surgery will further benefit.

In spite of the promptness of the X-ray Department, the general effect of a patient having an X-ray is, in over 90 per cent. of such patients, to add over an hour to the total time spent in the Surgery. This extra half-hour is by no means wasted. It arises from the procedure of collecting plates from the X-ray Department, examining them, and, on occasion, consulting colleagues and the X-ray Department about them. There is no doubt that the installation of the direct inter-communication line between the X-ray Department and the Surgery has greatly helped liaison between the two, and has resulted in much time being saved. No very great reduction in this average total time period for an X-ray investigation, *i.e.*, an hour, can be expected without sacrifice of proper care.

(III) *Analysis of cases spending over* 180 *minutes in the Surgery.*

(43 Sick and 60 Accidents)

103 out of 1,500 cases (7 per cent.) spent more than 3 hours in the Surgery. The chief single cause was the need for X-ray—24 of these 43 sick were X-rayed and 54 of these 60 accidents. In the majority of the remainder there was some very necessary cause of delay such as need of lengthy observation after a head injury, delay before anæsthesia because of a recent meal, need of special investigation like a blood carboxy-hæmoglobin, need of multiple telephone calls to the patient's doctor, previously visited hospital or relieving officer.

Five cases (.3%) spent 300 minutes or more in the Surgery. These were cases both of clinical difficulty and difficulty in admission due to shortage of beds or doubt as to their best disposal. For most of them more than one Take-In Officer was called, and many telephone calls made—to E.B.S., other hospitals, relieving officers and general practitioners. As there is no limit of time within which the patient must be admitted, such occasions are always prolonged—generally unduly so.

(IV) *Analysis of time for cases admitted to the Wards and effect of New Signal System.*

At Guy's it is, of course, the Take-In House Officer for the week (House Surgeon, House Physician, Children's H.P. or R.O.) who has the decision and responsibility for admission of individual cases. He is the person who knows best what beds are available, can be made available or will become available that day, and what future commitments the Take-In Firm has already made for these beds.

The old system of calling the Take-In House Officer still existed in December. That is the O.P.O. rang the College Porter who then rang (on one of his 2 lines) the various wards and theatres where this very busy and mobile House Officer might be. Before this Officer was contacted, other urgent calls from other parts of the Hospital for other House Officers might have to be made through the same porter. The House

Officer has, however, many calls on his time and it may not be possible for him to go immediately to the Surgery when called. For these reasons there has been for many years the ruling of the Superintendent that when the Take-In Officer has not arrived at the Surgery within 10 minutes of being called the O.P.O. may, if he thinks it necessary, order the admission. This ruling is seldom invoked because it dislocates the working of the Take-In Firm.

During the last three months the new signal system has been in operation to the great advantage of the admissions. The College Porter now on being told a House Officer is wanted in the Surgery simply switches the appropriate light signal for that House Officer. This registers in all wards and departments of the Hospital. On seeing his signal the House Officer contacts the College by phone and learns where he is wanted.

The comparative results for the two systems were demonstrated when this aspect of the Timing Investigation was repeated after the installation of the new signal system in April, 1949.

	Dec., 1948 (old calling system) For 63 calls in three weeks *Approx.*	April, 1949 (new signal system) For 104 calls in four weeks
Less than 5 minutes	0	45 per cent. (many were 1—2 minutes)
5—10 ,, ...	30 per cent.	30 per cent.
10—20 ,, ...	60 per cent.	15 per cent.
20—30 ,, ...	5 per cent.	10 per cent.

Cases needing admission spent longer in the Surgery than the average. Thus 66 per cent. of the Sick admitted were over 100 minutes in the Surgery (cf. 20 per cent. of all sick) and the same figure—66 per cent. for the Accidents (cf. 40 per cent. for all accidents). Four of these Accidents and one of the Sick were over four hours in the Surgery.

The average time taken from telephone call from the Surgery for the Take-In Firm until the Take-In House Officer left the Surgery having seen the case was just under 40 minutes. Such delays as did occur in the arrival of the Take-In House Officer were almost always due to the difficulty and delay in contacting him. Since the new signal system these delays occur only when the Take-In House Officer is in some part of the Hospital without the signal lights.

Although either or both of the clinical and administrative parts of admission could readily be taken over by a single Admitting Officer (as in many Hospitals) this does not seem to be necessary. The responsibilities for admission of emergencies are a traditional and valuable part of the O.P.O. and House Officer appointments at Guy's. More senior resources for consultation on these problems at the request of the O.P.O. or House Officer are available—clinical via the Casualty Surgeon, administrative via the Admitting Officer. If all decisions regarding emergency admissions had always first to be referred to either of these two more senior doctors (such as would make Guy's arrangements similar to a number of Teaching Hospitals) I do not believe that there would be any real gain to the patients. There does not seem to be any difficulty in maintaining a supply of House Officers capable of discharging these responsibilities.

(V) *Analysis of times taken by Dresser and O.P.O.s to see cases.*

(Most of these figures are based on samples of the consolidation sheets, not the whole 1,500 cases.)

Just over 50 per cent. of all patients were seen by Dressers within ten minutes of arrival in the Surgery; between 80–90 per cent. were seen within thirty minutes.

Just over 60 per cent. of all patients were seen by the O.P.O. within 20 minutes of arrival; 70 per cent. were seen within 40 minutes. It must be noted that by the time the O.P.O. sees a patient, the history, preliminary examination—including urine test and B.P. record—and much of the clinical and hospital documentation have been completed by the Dresser.

It is, of course, clear that the Dresser's examination is not a loss of time to the patient, or for the Dresser's educational benefit alone. The system at teaching hospitals of repeated history taking and examination by more than one student and House Officer before the case is presented for final decision by Staff Member, is one which probably makes for a higher general standard of diagnosis and treatment with difficult and complex cases than is otherwise obtainable, especially when many patients have to be seen and treated every day.

(VI) *Analysis of Evenings—7–9 p.m.*

The time between 7 and 9 p.m., just after the change-over when the two O.P.O.s and the three Dressers were replaced by one Assistant House Surgeon (A.H.S.) and two Dressers, who have then to deal with the post-supper influx, is known to be a time of difficulty.

Times taken for treatment, for X-ray, and for call of Take-In Officers are similar to other periods. But 44 per cent. of Sick spend over 100 minutes in the Surgery (cf. less than 20 per cent. of general average for Sick); and nearly 50 per cent. (as compared to average 40 per cent.) of Accidents spend more than this time in the Surgery.

The chief cause of the increased times was the delay in seeing Dressers and A.H.S. Less than 40 per cent. (of the average 50 per cent.) of cases were seen by Dressers within 10 minutes. Only just over 30 per cent. (cf. average 60 per cent.) were seen by the A.H.S. in 20 minutes; just under 70 per cent. were seen in 40 minutes; about 15 per cent. were not seen for an hour, and 2–4 per cent. waited 2 hours to see the A.H.S.

Because of the difficulties and delays in this 7 to 9 p.m. period the rota of A.H.S. and O.P.O. has recently been changed. Only one O.P.O. now goes off at 7 p.m. when the A.H.S. comes on. The other stays on till 9 (taking half an hour for supper, about 8). This means that if, as is likely to happen, the A.H.S. has calls to the wards between 7 and 9 or has difficulty in finishing his dinner before 7, there is still an O.P.O. in the Surgery and the work there does not suffer. Under the old system it was difficult for an O.P.O. to take on a long case after about 6.30 as he would have to hand it over at 7. The back log of patients therefore tended to start well before the A.H.S. was due to arrive. Now when the second O.P.O. goes off at 9 p.m. things are generally fairly quiet, and the A.H.S. has sole responsibility for the Surgery until 9 a.m. next morning.

NOTE ON GEOGRAPHICAL DISTRIBUTION OF DOCTORS REFERRING CASES BY LETTER TO THE FRONT SURGERY.

Over a period of six months a record was kept of the doctors who referred patients to the Front Surgery by letter. There were 862 of these letters; 7 to 8 per cent. of the total number of patients during the second half of 1948. The 92 per cent. who came without letters were almost exclusively local, that is Borough, S.E.1, inhabitants, or people who work in the Borough.

The main information obtained from the analysis of doctors' letters is as follows :—

Over 60 per cent. (514) of the doctor's letter cases come from the Borough, S.E.1.

Over 80 per cent. come from the nine neighbouring postal districts of Southwark (514), Walworth (68), Bermondsey (49), Peckham (32), Camberwell (17), Deptford (12), Eltham (10), Brockley (10), Streatham (10).

These postal districts are in the South-East Region. Although we overlap in Peckham and Camberwell with the other teaching hospital of the Region, we do not do so to the same extent with St. Thomas's which is nearer, although in the South-West Region. Only two doctor's letter cases came in six months from Lambeth.

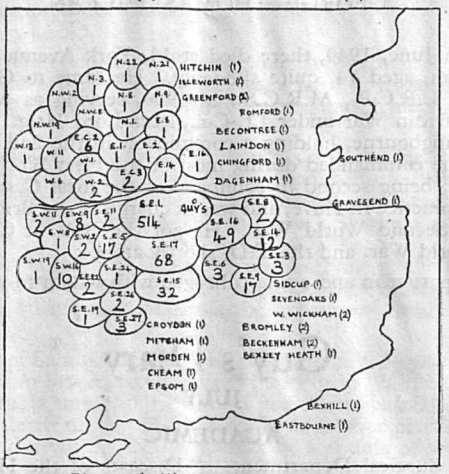
It is interesting to note that the Doctor who lives nearest to the Hospital sent the most patients during the period (90). This figure is in part due to his consistent courtesy in writing letters.

The effect of the National Health Act on the Surgery has been a marked decline in the attendance of the Sick, especially women (a fall of about 20%) and children (a fall of about 60%). These are the people who would previously have had to pay directly for their G.P. services. They are now attending him for many things for which they previously came to the Surgery without a doctor's letter. Furthermore, many local doctors are learning that patients without acute symptoms can (should) have their letter to the Hospital addressed to the Appointment Clerk for the appropriate out-patient clinic, if they are to be spared a preliminary (and generally unnecessary) visit to the Surgery. The effect of both these changes has been to increase the proportion of Accidents seen in the Surgery, though the total accident figure seems to be constant—at 8,000 to 10,000 a year for the last sixty years. Few accident cases have Doctor's letters, they come direct themselves, or by ambulance to the Surgery.

The map shows the distribution by postal areas of these doctors. The letter cases coming from a distance, *e.g.* Plymouth, Hastings, Grantham, have been mostly lorry

drivers, people on holiday in London or others in transit. They are chiefly ambulatory accident cases.

Walsall (1) Grantham (1)



Plymouth (1)

Map to show distribution by postal area of patients coming to the Surgery between July and December, 1948, with a doctor's letter.

The London part of this map gives a fair picture of the area the Hospital has drained for two centuries for acute Sick and Accidents. The area of drainage to out-patient clinics by appointment is a different matter, and is of course less parochial and more Regional and National.

SUMMARY.

1. An account is given of the time taken for the diagnosis, primary treatment and disposal of 1,500 consecutive cases coming to the Surgery in December, 1948. Almost all these cases were acute Sick or Accidents ; the proportion of Sick to Accidents was something under 2 : 1.

2. 80 per cent. of the Sick and 60 per cent. of the Accidents spent less than 100 minutes in the Surgery. 7 per cent. of all cases spent more than 3 hours in the Surgery.

3. Over 80 per cent. of patients X-rayed spent less than 30 minutes in the X-ray Department. The time in the Surgery, for patients X-rayed, from decision for an X-ray to decision on treatment after seeing the X-ray plate, averaged about 60 minutes.

4. In cases of excessive delay (.3 per cent. of patients were over 300 minutes in the Surgery), the chief single cause had been the difficulties in disposal ; that is the need of calling more than one Take-In Officer, and of telephoning several outside bodies. A time limit after which a bed must be found for the patient within the Hospital might be a worth-while safeguard against the manifest dangers involved in such long delays.

5. The advantages of the new Signal System to the cases admitted to the Hospital from the Surgery are discussed.

6. An additional note is made of the distribution of Doctors sending patients by letter to the Surgery. As would be expected, these are chiefly parochial (S.E.1), or metropolitan and less National than the distribution of letters to Out-patient clinics.

The investigation described above added considerably to the work of the permanent staff of the Surgery—Sister Grimwood, the Nurses, the Secretaries, Miss Hornby and Miss Jervis. It was only made possible by their consistent help and co-operation.

REFERENCES

(1) Clarkson, Patrick, Outpatient Arrangements and Accident Services. *Guy's Hospital Gazette*, 31st July, 1948.

Obituary

GEORGE THOMAS WILLAN.

H.S.H. writes :—

ON Friday, 24th June, 1949, there died at 14, York Avenue, Hove 2, Dr. George Thomas Willan, aged 74, quite suddenly. He came to Guy's from Cambridge and took the L.R.C.P., M.R.C.S., in 1900, serving as M.O. to 17th Lancers during the South African War under Lt.-Col., later Lord Haig. He then practiced in St. Austell and Sittingbourne, holding a commission in the 2nd Home Counties Field Ambulance, which he commanded during most of the First World War, after which he practised in Carlisle, being second in command of the local Casualty Clearing Station. In 1933 he came to practice in Hove, and was in charge of the Brighton Camp Reception Station during the Second World War. He got the B.A. at Cambridge, the D.S.O. during the First World War, and the T.D. shortly after.

He was a keen sportsman and a fine colleague with whom to work.

Guy's Diary

JULY

ACADEMIC

Exhibition. Surgical Department. "Diseases of the Hip."

18th. 12.00. Prof. Kurt H. Thoma, D.M.D., F.D.S., Harvard University. Dental Clinical Lecture. "The Surgical Correction of Jaw Deformities." Anatomy Theatre.

1.00. Dr. Boland. Clinical Lecture.

3.30. Demonstration of Skin Diseases. Preclinical Classroom.

19th. 1.00. Professor J. M. Macintosh. "Housing of Doctors."

21st. 1.00. Mr. Eckhoff. Clinical Lecture.

4.30. X-ray Meeting. Gordon Museum.

22nd. 1.00. Dr. Hampson. Clinical Lecture.

23rd. 10.00. Surgical Department. Clinico-Pathological Meeting. Anatomy Theatre.

25th. 1.00. Mr. Stamm. Clinical Lecture. "Fractures involving the Elbow Joint."

3.30. Demonstration of Skin Diseases. Preclinical Classroom.

26th. 12.00. Neurological Demonstration. Preclinical Classroom.

1.00. Dr. Lovatt Campbell. Lecture. "The Colonial Service."

28th. 4.30. X-ray Meeting. Gordon Museum.

SPORT

23rd. 11.30. 1st XI. *v.* Old Whitgiftians (Away).

24th. 2.00. 1st XI. *v.* Sutton Tramps (H.O.P.).

30th. 2 00. 1st XI. *v.* Finchley (H.O.P.).

31st. 11.30. 1st XI. *v.* Mr. J. Tanour's XI. (H.O.P.).

The Steele Diaries—IX

THE HOSPITAL (continued)

4th January, 1865.

Considerable alarm was caused in Philip Ward on Sunday last from the attempt of one of the patients to commit suicide. The man was admitted ten days since on the recommendation of Dr. Habershun, and it appears had previously attempted suicide. He had secreted himself in the scullery unknown to the nurses where he attempted to strangle himself with a pocket handkerchief. Considerable difficulty has been experienced of late in ridding the wards of maniacal cases.

25th July, 1866.

In anticipation of a possible outbreak of cholera in the district, Mark Ward is being kept in reserve for patients of one sex. There is not at present any separate vacant accommodation for both sexes but if necessary Esther Ward could, without much inconvenience or difficulty, be converted into a Cholera Ward. Since its appearance

in London, 3 cases only of Asiatic Cholera have been admitted to the Hospital, 2 of which have died. The number of patients suffering from diarrhœa have greatly increased during the last fortnight, but during the last two days they have diminished much with the corresponding diminution in the temperature of the air.

5th September, 1866.

32 cases of Cholera were admitted during the month of which 12 terminated fatally. Since the first appearance of the epidemic 37 cases have been admitttd to the wards of which 14 have died, 20 have been discharged cured and 3 remain under treatment.

12th September, 1866.

The only patient remaining in the Cholera Ward is a young girl who is able to leave the Hospital. Since last Wednesday one patient has been admitted who died a few hours after admission. Dr. Stevenson, the Chemical Assistant, was attacked with Choleraic symptoms in the Laboratory on Monday last and now occupies a private room in the Clinical House.

Harriet Abbot, a night nurse, who had been in the service of the Hospital for a few weeks only was attacked with Cholera while in the discharge of her duties and died on Thursday last. She was buried on Monday at the expense of the Hospital.

5th December, 1866.

A patient of the name of Samuel Creebo, who gave his age at 54 years and his residence at 3, Redcross Street, Union Street, was admitted into Philip Ward on 26th ult., and was known to have a considerable sum of money in his possession which he refused to deliver up to any one. On his death on the 28th ult., gold and silver pieces to the amount of £171 15s. 0d. were found sewn up in the pockets of a couple of waistcoats which he retained in his bed wrapped in a handkerchief. From this sum, £2 5s. 0d. had been deducted to cover the funeral charges and a deposit receipt for £169 10s. 0d. has been obtained from the Bank in case the money should be claimed by the man's relations.

24th July, 1867.

It is very desirable that another small screen should be got for Lydia Ward as the present screen is not sufficient to enclose the bed of a patient when subjected to private examination.

21st August, 1967.

Among the unusually large number of deaths registered during the week, amounting to 18 in all, there is a case of a nurse in Clinical Ward who died from Typhus Fever, contracted in the course of her duties.

The thunder storm on Monday night and Tuesday morning excited considerable alarm among the patients, especially in the female wards. In Miriam Ward the rain came through the ceiling and flooded the ward. The cause of this evidently arose from some obstruction in the rain waste pipes.

18th December, 1867.

An attempt to diet the patients on Australian beef was made in Job Ward on Saturday last. The amount of meat used for 14 patients on middle and full diets was 6 lbs., but this amount did not appear to be adequate to the wants of the patients.

7th October, 1868.

A portion of the fire brigade with two steam propellers were sent to the Hospital yesterday morning to wash the stone work in the front part of the building. After a delay of nearly two hours they accomplished their object. This delay was mainly caused by the space which formerly indicated the position of the fire plug having been filled up by gravel and no one being able to indicate its site. Half an hour's delay also occurred before a screw could be obtained to turn on the water to the hydrants in the middle square.

13th January, 1869.

Some mystery as well as a good deal of inconvenience has been felt in Luke Ward lately from the oozing out, apparently from the wall which divides it from Charity Ward, of some fœtid discharge which cannot be traced to arise from any source within the wards.

10th March, 1869.

A curious accident occurred on Saturday last which stopped the water supply for a time to Hunt's House. It was discovered that a pigeon had got into the large water cistern at the top of the building and blocked up the entrance to the main supply pipe.

31st March, 1869.

Last Thursday night betwixt 11 and 12 o'clock, much excitement was produced throughout the Hospital in consequence of an alarm that the laundry was on fire, and caused by a fire which had broken out in a wooden building situated immediately behind

the flock room. For a time there was some reason to apprehend an extension of the fire to the Laundry Buildings and to avoid damage all the movable furniture and linen of which there happened to be an unusual quantity (clean and foul) were removed into the Clinical House and the grounds. They were afterwards replaced when the fire was got under.

14th April, 1869.

On Monday night, shortly after 11 o'clock, great alarm was caused throughout the Hospital from a fire which had broken out in the large warehouse facing the back of the museum and forming a portion of the boundary wall of the Hospital grounds. At no time was any danger apprehended from the vicinity of the Hospital to the fire, but a fire engine was brought into the Hospital grounds for the purpose of attending to the fire in the rear. Much time was lost in fruitless attempts to render available the 3 hydrants at the back of the Hospital and which are said to be in direct communication with the mains of the Water Company. The absence of the plumber during the whole of the night caused considerable inconvenience.

Correspondence

Reports upon Games

SIR,—Thirty-two years have passed since I left Guy's, with the result that there are now only some three or four of my contemporaries remaining at the hospital. But like many other old Guy's men I still take a very keen interest in the doings of "the hospital" in the field of sports, and I still subscribe to the *Gazette*, chiefly to read the accounts of such sports—in fact I always turn to the sports columns first when opening my copy, for clinical lectures lose much of their attraction when one unfortunately no longer knows the lecturer's personality. Second to the sports column in appeal to me comes the pass list, where one looks for the names of sons of one's own contemporaries, and after that, alas the obituary notices.

During the war the sports columns were sadly neglected owing to difficulties with paper supplies and the time available for sports, but now surely these difficulties should be decreasing; but the reports of to-day upon sports are really atrocious and seem to be held in very little esteem, a situation which I feel should be remedied if the *Gazette* is to maintain its appeal among old Guy's men, for surely adequate reports are an additional encouragement to the various teams, and publicity acts as propaganda to spur on individuals to be chosen to represent the hospital.

In looking through my number of June 18th this year, I find a whole page with a long garbled report of the cricket cup-tie against Bart's which does not even give the Guy's score or names of the team. The following page gives brief figures of several matches spread over some four weeks—that of May 22nd *v.* Old Blues gives no scores at all! On the next page one reads a few notes about the United Hospitals' athletic meeting, but no report of the placing of Guy's or any other hospital is included.

Going back a few months with regard to rugby football, I must say that the report of the cup final against Mary's, with the controversy which gained so much notice in the daily press, was a very inadequate description of the match. Again, on that day, the junior rugby cup final was being played earlier on another pitch. Reports of this match were completely omitted, as with all other "A" team fixtures, although Guy's "A" were then playing Mary's. Also with regard to the rugby team, it was announced in the fixture list that a tour was to be made at Easter, but we have been given no details of where this tour took place, or what were the results. It used also to be the custom to publish the names of the teams at the end of each report upon a match—even last year full score sheets of the Guy's team at cricket were given, but this custom has latterly been dropped.

I hope my complaints may help to bring about a return to the old customs of reporting, which did at least help to keep alive keen interest in the hospital games, both within its walls and also in the wide circle of old Guy's men whose pride in the hospital is second to none. Publicity is a great factor in improving results, never overlook that fact, and poor reporting is apt to give an outsider the impression that there is a general lack of interest in the doings of the hospital in the sphere so neglected. If Guy's is to maintain the proud position in sport which it has held for so very many years, it is high time this complaint is remedied.

Yours faithfully,

H. STEWART WACHER.

The Wilderness,
St. Stephens, Canterbury.

Sport

CRICKET

Guy's *v.* Three Counties Hospital

July 9th, 1949.

Away. Result—Lost.

Guy's 173. T.C.H. 174—5.

Blake 61 ; Russell 58 ; Tweed 3—36.

A somewhat protracted train journey to Hitchin and, from there on, a highly harrowing lorry ride saw the Guy's XI, that is to say its usual commencing tally of nine, at the pleasant grounds of our opponents in Bedfordshire.

Russell, fortunately having called correctly, took Blake in with him to open the innings and by good aggressive play, in which Blake was the predominant partner, they gathered together 70 odd runs in the 45 minutes before lunch. Russell was particularly adept at forcing away past mid-wicket the ball pitched on his toes, and Blake, apart from a tendency to flash at rising balls outside his off-stump, which should have cost him his wicket twice and might have done on sundry other occasions, showed us some dazzling cover drives and well-timed cuts.

By lunch the two truants, both of whom claimed that there was no more than a coat of nationalised varnish between themselves and the vanishing tail of British Railways, had arrived, having atoned for their lethargy by forking out ten bob apiece in taxi fares, which one at least had the temerity to ask for out of club funds.

Lunch over, the serious business began again. Before long, however, Blake flicked once too often. Justice had come into her own and the fastish left-hander, Callingham, who had bowled unchanged so far, had his reward. Blake and his skipper had given their side a fine start, 110—1. Prentice came and went in no time at all, victim also to Callingham, 110—2. A few more runs were added and then Russell ran himself out.

Thereafter wickets tumbled fast and only Jones with a sturdy innings of well-made strokes, stood between the opposition bowlers and what must have seemed to them, as they ate their lunch, the near-impossible. The innings closed sometime before tea and the home side were set, 174 to make in a little more than even time.

Russell and Jones opened the Guy's bowling, but the batsmen had little difficulty in scoring off what was not as accurate as it might have been. Jones indeed seemed on occasion to think that " over-ball " meant one which sailed over the batsman's head into the wicketkeeper's gloves. He did tap the batsman's pads with a good one but the umpire was unsympathetic to his cajoling call.

Tweed eventually was called upon and with his first ball, one which straightened out, had Short lbw. The next man in, Bircumshaw, hit hard for 31, before Blake, standing back, took him off Russell, 99—2. At 133, the left-handed Mays stepped in front of a straight one from Tweed who also had the next batsman well stumped by Blake at 151, and clean bowled the opening batsman, Smart, a run later.

There was a definite prospect of a tight finish at that time but it was soon dispelled by the next pair who hit off the runs with half-an-hour to spare.

A word is due to the Guy's fielding which was very good throughout. Blake's work behind the wicket was clean and quick, and Meyer and Sturdy excelled with some fine saves at a time when runs were coming far too easily.

Inter-Hospitals Cricket Cup
2nd Round (replay)

Monday, 11th July, 1949.

Guy's *v.* St. Bartholomew's

At H.O.P. Result—Won.

It was a hot day and the pitch was well watered and the toss was vital. Barts won, batted and quite carefully pushed the score along to 49 for 2, when Tomlinson, who had batted perhaps a little nervously for him, hit Gray for three successive fours and the battle was really joined.

At once Barts were unlucky. A brilliant throw-in by John Williams ran Tomlinson out by yards on a misjudged, if not downright foolish, single to cover. 59 for 3. Peter Moyes had something to answer for here. Then Brainbridge, with the highest backlift in cup cricket and the surest cover drive, and David Cairns, the wary, the cautious, pushed, and finally confidently took, the score along in both hands to 165, when Cairns in attempting to drive Tweed, lofted a sizzler to extra cover but straight at Graham who unhurriedly caught it.

Brainbridge, however, was intent on a century. Carefully he picked his way through the seventies and when drinks came he stoically refused them. But at 95 with the total 216 he slashed at Graham and Tweed took a not too difficult catch at cover. Graham at this point was hoisting the ball and really asking to be hit, but with the proviso that the fielders

were right out and waiting for the ball that did not run along the ground. Hence when they forced the pace they collapsed, Graham with 43 for 4, being largely instrumental. At tea, after four hours and ten minutes batting, they were all out for 262, and Guy's were left three hours to get these runs. For those to whom mathematics is an esoteric art practiced by schoolboys, that meant 87 runs an hour. That is fast; indeed for cup cricket that is meteoric.

Blake and Woodford opened and Blake really meant to make runs to-day. Usually the most happy-go-lucky batsman in the side, this time monopolising the bowling, dourly watching the good ball, controlled but severe with the bad, he nursed the opening partnership to 103 in 100 minutes before Woodford went for 35.

Then came Russell who, though not a classic bat, bats good beef to ball and provides wholesome cricket fare for those who understand the finer points and for those who like to see a good bash. At once he bashed and in 30 minutes the score went to 169 when Blake was out for 91, dismissed by a brilliant catch in the slips, a fitting end to a memorable innings.

From this point on it was all Russell and drives over their heads, through their hands as well as simmering along the ground were thrown in. Lipington appeared transiently and was gone and then in a final relentless onslaught the Barts attack was dispersed to the winds as Guy's hit 263 for 3 in three hours dead, with Williams and Russell thrusting and bludgeoning respectively. A noble victory. Russell (98 not out) never gave up, and if not a tactically subtle captain he had the determination to win that was the deciding factor.

Barts 262—Cairns 44, Brainbridge 95, E. W. Graham 4 for 43.

Guy's 263—D. Blake 91, J. F. Woodford 35, P. S. B. Russell 98 not out, J. D. Williams 30 not out.

Guy's now meet St. Mary's in the Semi-Final.

OTHER RESULTS.

1st XI. *v.* Kenley

June 11th, 1949.

at H.O.P. Result—Drawn.

Guy's 167—3 dec.; Kenley 110—8.

(Russell 53, Lipington 56 not, Platt 38 not, Smith 5—45).

1st XI. *v.* Metropolitan Police

June 18th, 1949.

at H.O.P. Result—Lost.

Guy's 156; Metropolitan Police 160—4.

(Blake 83, Woodford 3—45).

1st XI. *v.* Horlicks

June 19th, 1949.

at H.O.P. Result—Lost.

Horlicks 162; Guy's 146.

(Gray 6—65, Woodford 3—53, Woodford 68, Russell 31).

1st XI. *v.* Bognor

June 26th, 1949.

at Bognor. Result—Won.

Guy's 244—6 dec.; Bognor 149.

(Blake 93, Russell 90 not, Tweed 5—23).

1st XI. *v.* Ealing Dean

July 2nd, 1949.

at Perivale. Result—Drawn.

Ealing Dean 159—1 dec.; Guy's 101—6.

(Russell 61).

1st XI. *v.* Streatham

July 3rd, 1949.

at H.O.P. Result—Won.

Guy's 159; Streatham 89.

(Prentice 57 not, Woodford 31, Graham 5—24, Woodford 3—27).

1st XI. *v.* Addiscombe

Away. Result—Won.

Addiscombe 130; Guy's 131—9.

(Tweed 4—27, Woodford 4—45, Hodson 23).

2nd XI. *v.* St. Thomas's Hospital 2nd XI.

June 18th, 1949.

at Cobham. Result—Won.

St. Thomas's 42; Guy's 43—6.

(Hodson 6—21, Fearn 3—19).

2nd XI. *v.* Chartered Banks

June 25th, 1949.

at H.O.P. Result—Lost.

Chartered Banks 146; Guy's 126.

(Robinson 6—36, Fearn 54, Robinson 26).

2nd XI. *v.* Lewisham

July 2nd, 1949.

at H.O.P. Result—Won.

Guy's 166; Lewisham 127.

(Hodson 48, Fearn 37, Carter 25, Croft 4—37, Hodson 4—43).

RUGGER CLUB DINNER

The Rugger Club, very much out to grass at this time of year, are to be congratulated on a rather adventurous move in arranging their dance in the face of very obvious difficulties. The Victoria Hall, the scene of many pre-war Guy's dances, proved on the night of Friday, the 8th July, to be a very pleasant spot to the many present who had not previously made its acquaintance, while the music, ably provided by Tommy de Rosa (of Resident's Ball fame) left nothing to be desired. Those present enjoyed themselves immensely, and if many well-known faces and figures were conspicuous by their absence, fun and games no less were had by all. Most of the stalwarts were there, and there would doubtless have been many more had the arrangements not been so hastily made, and had the season been more appropriately chosen.

Nevertheless, the organisers, Messrs. Moore and Robinson are to be congratulated on, and thanked for, the extremely enjoyable evening which their labours provided, and we look forward to the regular re-establishment of the Rugger Club Dance in coming seasons, if possible at a time of year when that club's supporters are feeling less lackadaisical.

ROWING

A. S. F. Butcher, the Guy's Olympic oar, won the Silver Goblets at Henley earlier this month. He also rowed in the Thames Rowing Club Eight which was only beaten in the final of the Grand.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

Applications are invited for the post of **Resident Anæsthetist.** Duties to commence on August 1st, 1949. Salary at the rate of £450 per annum, less £100 per annum for board and lodging. Applications should be lodged with the Superintendent on or before July 25th, 1949.

APPOINTMENTS

Dr. R. West, M.R.C.S., L.R.C.P., D.P.H., appointed Medical Officer to the National Dock Labour Board's Medical Scheme for the Humber Ports.

MINISTRY OF HEALTH

Professor R. V. Bradlaw has been appointed Chairman of the Dental Standing Advisory Committee.

MEDICAL AUXILIARY WORKERS

The following Guy's men are included on the Committees set up by the Ministry of Health to review questions of recruitment, training, and qualifications of medical auxiliary workers in the National Health Service :—

Physiotherapists.—Mr. T. T. Stamm.

Radiographers.—Professor G. Stead.

Speech Therapists.—Dr. C. C. Worster-Drought.

ROYAL SOCIETY OF MEDICINE

At the Annual Meeting of the Society on July 5th the following Guy's men were elected as officers :—

Joint Hon. Treasurer.—Mr. L. R. Broster.

Member of Council.—Professor G. Payling-Wright.

PASS LIST

UNIVERSITY OF OXFORD

B.M., B.CH.

Trinity Term.

Medicine, Surgery and Midwifery.

W. J. C. Symonds

UNIVERSITY OF CAMBRIDGE

FINAL M.B. EXAMINATION.

Easter Term, 1949.

Part I.—Surgery, Midwifery and Gynæcology.

R. G. Beard
M. V. Doherty
A. Gol
M. J. Hunter
K. F. Robinson
H. Schlossmann
R. H. R. White

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

FINAL EXAMINATION.

June, 1949.

Part I.—Surgery.

M. F. Ashby
J. D. Barker
D. R. Boswell
R. E. Breen-Turner
W. A. B. Brown
D. W. Campbell
K. E. Clokey
A. N. du Plessis
P. A. Gardener
G. D. Gibb
A. L. Guilianotti
P. Glazebrook
J. M. D. Grant
P. D. V. Harrett
H. C. Hole
M. Kaye
J. H. Keeling
P. J. A. Lawrence
B. E. Lawson
N. I. Lewis
E. D. Morgan
K. Paul
A. B. Price
M. J. Quelch
P. Readings
W. J. A. Reed
J. D. R. Shaw
W. M. Sheeran
P. H. Tucker
B. R. Venning
G. J. L. Want
D. R. Whittington

Part II.—Dental Surgery.

A. A. Bailey
R. D. Baker
D. G. Bunker
A. P. Demajo
W. Finkel
D. G. D. Harris
J. H. Keeling
M. M. Keen
M. B. Lacey
K. Paul
B. H. Wilshere

FIRST EXAMINATION.

Anatomy and Physiology.

A. E. Castle
J. A. P. Darvell
J. R. Flynn
D. K. Hardy
R. G. Kettle
J. Lopian
A. E. Milne
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Special Anatomy and Physiology.

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D. M. E. Jennings
A. F. Jones
R. G. Kettle
J. C. Matthews
J. A. Mepsted
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S. Morgan
O. D. Nazroo
D. H. O'Flynn
A. G. Prince
F. Quail
E. P. Reynolds
C. F. M. Robinson
R. Sharp
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D. L. J. Thomas
D. J. Timms
J. M. Turner
E. Tweddle
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June, 1949.

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SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

June, 1949.

Surgery.

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H. E. G. Dyer
M. C. H. Jackson
*F. W. Retief

Pathology, Bacteriology and Forensic Medicine.

R. J. Aspinall
C. J. G. Menzies
P. B. Poole

Medicine.

J. T. Cecil
C. J. G. Menzies

Midwifery.

M. C. H. Jackson
S. A. Jolliffe
C. J. G. Menzies

* Have completed the examination.

PAPERS BY GUY'S MEN

Allsopp, C. B., and Another. Tissue culture experiments on the Biological action of Methyl bis (B-Chlorethyl) Amine and its Hydrolysis Products *Cancer Res.*, 1949, **9**, 238.

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Symonds, Sir C. Facial Pain. *J. Dent. Ass. South Africa*, 1949, **4**, 247.

CHANGE OF ADDRESS

C. C. Worster-Drought, M.D., F.R.C.P., 82, Portland Place, W.1. (Tel.: Langham 2230.)

H. J. Goldsmith Lt. R.A.M.C. (402011), B.M.H. Fayid, M.E.L.F.

BIRTHS

HARVEY.—On July 1st, 1949, at the Wilbraham Nursing Home, Sloane Street, to Diana Mary (née Peerman), wife of Douglas Wilson Harvey—a son (Ian Wilson).

NEVE.—On June 25th, 1949, at Guy's Hospital, to Elizabeth (née Hunt), wife of Richard Neve—a sister for Michèle.

RUDMAN.—On June 10th, 1949, at Gerrards Cross, Bucks., to Margaret (née Shinkfield), wife of D. J. Rudman—a son.

TINKLER.—On June 25th, 1949, at the Manor Hospital, Walsall, Staffs, to Marjorie (née Harnaman), wife of Stanley N. Tinkler, L.D.S. R.C.S. (Eng.)—a daughter.

MARRIAGES

KESSON—GRAHAM.—On June 18th, 1949, at St. Mary's, Cadogan Gardens, London, Cyril Wyllie, M.R.C.P., M.D., son of the late John Elrick Kesson, M.D., and of Mrs. Kesson, Norbury, S.W.16, to Rosemary, M.B., B.S., daughter of Mr. and Mrs. A. C. Graham, Transvaal, South Africa.

DEATHS

WILLAN.—On June 24th, 1949 (suddenly) George Thomas Willan, D.S.O. B.A., M.R.C.S., L.R.C.P., of 14, York Avenue, Hove, Sussex, aged 74 years

EDS. {H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

FOR some considerable time, it seems, Passim has been concerned with matters of weighty political import, accounts of historical significance or salvoes of undisguised criticism. But this is no occasion, in the last week of July, for an essay on ponderous dialectics. The weather has been brilliant for weeks, even tropical in its impact, and though a most menacing dock strike beset London for all too long that has apparently been at last resolved, albeit with a considerable attempt at " face-saving " on all sides. And while, across London Bridge the City gentlemen still deign to discard their dark suits and waistcoats, notwithstanding the temperature, their lady accomplices have no such inhibitions and lend colour to the scene both with gay dresses and painted skins.

Under such conditions trade balances and the other grim problems of the world take on an unreal and distant air. Instead, we think of the cricket field, be it village green or county ground, and the scene that is essentially English. After all, are we not enjoying a visit by a New Zealand touring side that plays a most attractive game and adds its special appeal? Throughout the land the agricultural shows are having in turn their brief days of competitive existence, testifying at once to the flourishing of what is still, after all, the country's basic and still largest single industry and undoubtedly one of the finest ways of life. Around the coast and upon the lakes and rivers thousands find recreation and grace upon the water, in large boats, in small boats, by motor and by sail. Is there any more striking demonstration of individuality than that to be seen among the various craft to be found in any harbour at this time of the year?

Perhaps, as Coward avers, only " mad dogs and Englishmen go out in the mid-day sun." But, in so doing, with a characteristic mixture of abandon and convention and frequently at considerable discomfort to themselves, they have a singleness of purpose—to enjoy life. Maybe this, after all, is a phantom quest, as the cynics would insist. Yet, despite the heat, the impedimenta, the refractory children, the congested stations, the utter impossibility of finding out easily and reliably at any British travel centre what services are available and the realisation that the procuring of meals or refreshments is practically out of the question, an atmosphere of fun prevails.

Whether we think back nostalgically to the boisterous Tudor era, to the spacious times of Victorian prosperity or merely to the more recent delights that a few were able to snatch " between the two wars," we should do well to realise that such glorious days were no gifts from the gods. Rather did they reflect an attitude of mind. There were troubles then as there are now, there were misfortunes, plagues and pestilences. But they were met with a sense of assuredness and endeavour, and with a will to win. The newspapers, too, were not filled with the present-day series of depressing reports and plaints of helplessness. Is it any wonder that so many turn now, as it were instinctively, to that last page bearing the sports news?

Within a hospital, sickness and the cruel blows which it inflicts upon personal and domestic life, constitute the principal theme of the drama. None the less, the stage is set against a background of cheerfulness and a décor of hope. To allow it otherwise would not only be to conspire in the tragedy but to bring down the curtain once and for all. That spirit born of knowledge and understanding, which infuses the medical profession in all its activities must, therefore, be spread throughout the land.

Guy's to-day is without much of its turmoil. In the front court the limousines are not so numerous and, in the Park, inert figures occupy deck-chairs or cover the grass in disconcerting array. The wards, too, are crowded as usual, but particularly gay with flowers. All, in fact, is less bleak.

The human body can tire with excessive effort; physiologists have an explanation for this phenomenon. Holidays, however, seldom afford relief. More often do they substitute one form of exercise, and frequently a more strenuous one, for that which is the habit. The mind, on the other hand, is not so obviously fatigued. Indeed, the brain through which it expresses itself behaves quite differently from, say, the locomotory system, in the course of its function. A vacation, then, has its greatest benefit in what it can do for the mind. The performance of thought may be no less, but the demands made upon it are not so exacting. As a result, intellect and emotion tend to achieve a more satisfactory balance. The temper threshold is raised, the power of reasoning becomes more fluent and hopes, fears, problems and achievements fall into proper relationship.

This is the holiday season. A number of our readers will already have been away; others are going or living in anticipation. We wish them all a good time, and are sure that when they come back, although they may not all have stayed at "that restaurant on the river bank where the swans glide past and food for gods and goddesses is served in the summer twilight," contemporary existence will seem less irksome and the daily news will be faced without a shudder.

BENEATH the heading "British Doctors visit Vichy," Franco-Anglo-American Press Relations report that "a group of British doctors headed by Lord Moran," recently visited the French Spas in Auvergne. Included in the party were Dr. and Mrs. Campbell. A most ambitious programme was arranged by the reception authorities with "a thorough visit to the Grand Thermal Establishment, under the direction of its chief, Dr. Lapierre, as well as to the Hydrology Laboratory, directed by Prof. Lescoeur, and to the bottling works and various springs. Dinners and receptions were held at the Grand Casino, the Golf Club, etc., presided by M. Victor Leger, Mayor of Vichy, M. Baugnies, President of the Vichy Company and attended by all the officials of the municipality and of the Company." We look forward to hearing more from Dr. Campbell about his trip regarding, of course, the therapeutic significance of all he saw.

PROFESSOR K. H. THOMA, D.M.D., Professor Emeritus of Oral Pathology and Brackett Professor of Oral Surgery at the University of Harvard, has recently been in this country where he delivered the Charles Tomes lecture at the Royal College of Surgeons and was awarded the Honorary F.D.S. One of the foremost members of his profession in the United States he acts as Consultant Oral Surgeon to the American Army and is also President of the American Academy of Oral Pathology. Although engaged on a strenuous tour of various dental centres throughout the United Kingdom and also in Europe before returning to the U.S.A, he nevertheless found the opportunity to visit Guy's on 18th July, where he delivered a clinical lecture on the "Surgical Correction of Jaw Deformities." The intention is to publish this lecture in a future issue of the *Gazette*.

FROM Yale, news has come that the two Guy's students there are having a very busy time, not only with professional studies but with sight-seeing tours throughout the land. Medicine by the American system is "all like Thursday afternoons at 4.30" (Vide: Lectures on Chemical Pathology—Guy's Hospital Medical School, Summer Term, 1949). One of them has contracted Glandular Fever, to find that Paul is on the staff at Yale and Bunnell is his assistant.

THE Council of the British Medical Association invites essays from bona fide students on "Clinical Teaching in Relation to the Practice of Medicine." The closing date for the competition is 31st December, 1949, and prizes will be awarded in accordance with the excellence of the essays submitted. Further particulars can be obtained from the Secretary, British Medical Association, B.M.A. House, Tavistock Square, W.C.1.

DR. KEITH SIMPSON needs no introduction to Guy's men. His recent work in connection with the Haigh trial has received wide publicity. We are, therefore, very pleased to be able to publish in this issue an article by him on medicine and the law.

FOLLOWING the installation of television apparatus in the Surgical Department at Guy's the Marconi Company reports that equipment of theirs is now being used at St. Thomas's to televise eye operations and at U.C.H. where a demonstration was given to the Gynæcological Congress recently held in London.

Guilty but Insane

KEITH SIMPSON, M.D. Lond.
Reader in Forensic Medicine, University of London.

THE English Law has one of its closest relations with medicine when the sanity of a man accused of crime is questioned. This is not a matter that the law can decide without recourse to doctors ; it is, further, a decision that must rest entirely with the honesty and integrity of the medical man.

Doctors of medicine are, on the whole, rightly respected for their sense of responsibility in public affairs. They are, on the whole, educated, and not without conscience in their respect for their duties as citizens. To put it shortly, doctors are, generally speaking, to be trusted, and this trust is, I believe, seldom misplaced. Medical men realise that they enjoy the high regard of the public and of courts of justice, and this tends to evoke their best qualities. Counsel may bristle a little, affect indignation at the stand a doctor takes, or even, looking away into the court for better effect, complain, " Are you seriously saying, doctor, that you think this trifling kick in the stomach from a horse caused deceased any inconvenience whatever ? "—may finally, after making no headway, sit down with a resigned, " As you please, doctor." But, in the end, if a doctor has reasoned his argument and can say not merely, " It is I who say this—I, Lord Bundle of Hiss "—but, better, " In view of the conditions I have described, I have no doubt it is proper to conclude that these remains are those of the missing ward sister," then the doctor can expect to carry his argument. Any jury will listen to reasonable argument and logical conclusion : the best teachers are those whose reasoning is so obvious that by the time they have come to their peroration there is hardly any need to make one. Such a witness is the doctor—except on those rarer occasions when he has been persuaded to say something his better judgment would refuse. No doctor should ever be persuaded so to prostitute his art.

Counsel may be permitted their black art of argument for defence—even hopeless defence—but a doctor's duty is undoubtedly to help the court attain the truth : it is no matter to him who wins. Most forensic experts would readily agree it is no concern of theirs whether the Crown achieves a prosecution or not : it is not their duty to act as detectives, to enforce order or to see criminal types put away, but merely to add an air of sanity and reason to legal argument that may otherwise be biased " for " or " against " accused.

Now to return *a nos moutons* : the case of R. *v.* Haigh is such an excellent example of a hopeless defence to a murder charge on a plea of insanity that reference to this common court problem for doctors is worth a few moments' reflection.

THE LAW.

The English law first made some provision for criminal offences committed by insane persons in 1843, as a result of the trial of a maniac called McNaghten, who had murdered Sir Robert Peel's secretary, a Mr. Drummond. Certain questions were put to a panel of judges, and the replies to these have become known as the " McNaghten Rules." They are short and quite clear in their meaning. It is upon them that any defence of insanity must rest.

Their substance is as follows :—

1. Every person " is presumed to be sane and to possess a sufficient degree of reason to be responsible for his crimes until the contrary is proved " to the satisfaction of a jury.
2. That " to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as
   (*a*) not to know the nature and quality of the act he was doing, or if he did know it,
   (*b*) that he did not know that he was doing what was wrong."

The phrase " what was wrong " has always been taken to mean " wrong " merely as distinct from " right " and not to demand a knowledge of the law of the land, though " the law is administered on the principle that everyone must be taken conclusively to know it without proof that he does know it. If the accused was conscious that the act was one which he ought not to do, and if that act was at the same time contrary to the law of the land, he is punishable."

3. If the accused suffers from delusions it will depend upon the nature of these in relation to his crime as to what responsibility accused must bear. He will be in "the same situation as to responsibility as if the facts with respect to which the delusions exist were real."

"For example, if under the influence of his delusion, he supposes another man to be in the act of attempting to take away his life, and he kills that man, as he supposes, in self-defence, he would be exempt from punishment." "If his delusion was that the deceased had inflicted a serious injury to his character, and fortune, and he killed him in revenge for such supposed injury, he would be liable for punishment."

4. A medical man, though not seeing the prisoner prior to trial "but who was present during the whole trial and the examination of the witnesses" can, where the facts of the case are not in dispute and the question of deceased's responsibility becomes a question "substantially one of science only," give his opinion on the state of the prisoner's mind at the time of the crime.

In the event of a verdict, after trial, of "Guilty but Insane" the accused is kept in custody as a criminal lunatic "during His Majesty's pleasure." The McNaghten Rules, in the hands of a good judge, are easily understood by a lay jury, and work with a leniency for the accused which has always distinguished the English administration of justice. Appeal can also cause a substitution of the verdict "guilty but insane" for guilty, or the Home Secretary may order the state of a prisoner's mind to be inquired into after conviction. The superintendent of a criminal lunatic asylum is required (under the Criminal Lunatics Act, 1884) to report once a year to the Secretary of State on the persons in his care, and the Secretary of State must review the condition, history and circumstances of each criminal lunatic once every three years, to determine whether he ought to be discharged or otherwise dealt with.

THE PLEA IN PRACTICE.

The essence of the matter is not whether accused was schizophrenic, epileptic, paranoiac, provoked by nagging, or merely unable to restrain the temptation of doing away with his tormentor, but whether disease caused some defect of reason which prevented him understanding what he was doing—or that it was wrong. The law does not recognise the "irresistible impulse."

The doctor who is prepared to give evidence for the defence can only help his counsel's argument if he can satisfy the jury on these aspects. It is not the slightest help to defending counsel, court or jury to diagnose disease of the mind and to give a long lecture on the nature, signs and symptoms of a mental disorder from which the accused is said to suffer—even if he really does suffer from it. Doctors can only harm their reputation by such appearances for the defence; notoriety rather than notability will be likely to ensue. The specialist will achieve no laurels but risk disrepute, and his profession is likely to regret their particular art being lent to such purpose.

Accused may, in point, be plainly mad, medically insane, eccentric or merely unrestrained in his enthusiasm for artistic licence, but it is of no avail to bring evidence of these eccentricities forward to excuse himself from the lawful consequences of acts of violence—assaults, rape, murder and the like. Haigh was said to regard himself as something of an artist in his practice of deception, his use of forgery for gain and in his skilful disposal of those whose money he could more easily reach by murder. It was devilish artistry of a savage, uncivilised, anti-social kind and incapable of excuse—so long as he knew (*a*) what he was doing and (*b*) that it was wrong. And if a pychiatrist is persuaded to say by a lay counsel that, after careful thought, he felt accused knew that what he had done was wrong and punishable, then he should never have been persuaded to go into the box at all—unless for the prosecution. This is where a doctor should weigh carefully the propriety of his giving evidence before committing himself to the witness box and exposing himself to skilled, instructed cross-examination by counsel. It was significant that the Attorney-General prosecuting in the Haigh case was able with ease to demolish the evidence of an experienced psychiatrist in court without even calling one of the several psychiatric experts who were sitting in court prepared to give evidence for the Crown.

THE JURY'S VIEW.

It has often been said that most persons for whom a defence of insanity is raised would not have given way to their impulse if a policeman had been at their elbow at the time, and this, as a lay evaluation, is not without its point. Juries are apt to use their commonsense when weighing the evidence. They pay little regard to an accused's plea that at the vital moment of committing a murderous assault he had a "black-out."

Only when medical evidence of epilepsy or some other disorder associated with " black-outs " in which crimes of violence may be committed unknowingly is produced is the jury likely to pay regard. I have this month seen a man whose body was scarred from falls and burns in epileptic seizures who stabbed his mother and set her alight with petrol, for whom such a plea might well be made. On the contrary, a young man who, in jealousy, battered his wife to death after a New Year's dance at Tunbridge Wells, and was able to remember leaving the dance hall with her on a difference of opinion, received little sympathy from the jury in his plea that his memory then failed him.

What is done with the body after a crime may affect the jury a great deal more than is strictly proper, for it is evidence of the reaction to a crime rather than of the state of mind of the accused at the time the crime was committed. In Lambeth in 1932 a quiet-living old gentleman strangled his wife because, after years of devoted attention to her in her enjoyment of vague ill-health, she called him " a clumsy old fool " when he happened to tread on her toe in helping her out of bed. Now he went straight into the back garden, leaned over the fence, and said to his neighbour, " Annie, I have done a dreadful thing, I've strangled Jane." He at once secured the sympathy of the jury by such an act, and it was not difficult to persuade them that the old gentleman's reason had temporarily given way.

If you find your mother-in-law dead at your feet bleeding from a head wound, and you realise that you are standing there with a bloodstained claret bottle clutched in your hand, you should undoubtedly reason that you may have done wrong. To hide the body is to achieve an air of guilt : to own up or expose the circumstances to the authorities for investigation is to secure sympathy and a better hearing.

In the Oxford " Pantry-boy " case of 1938 I was asked to help the defence, and as it was clear that there had been a brutal sadistic murder committed by the theological student who was in custody, I suggested that the late Dr. R. D. Gillespie should examine the boy to see whether he could offer assistance to the defence on the grounds of insanity. Dr. Gillespie was, as always, remarkably fair in his decision. He recognised that the boy was a schizophrenic subject—suffering from the split mind that so commonly results in emotional outbursts and violence—but he felt, as the boy had shown a detached interest in the details of his crime and had made attempts to dispose of the body secretly, that he could not honestly say either that he did not know what he was doing at the time, or that it was wrong. It is well that medicine enjoys decisions of such integrity—even though the court may hear nothing of them.

In the Heath case, where a woman of the kind who enjoys beatings at the hands of masculine types met her death whilst being whipped, gagged and bound in her bed, accused undoubtedly suffered from disease of the mind and undoubtedly experienced an emotional outburst in which he might or might not have realised the nature, quality and ultimate consequences of his act. But Heath made the vital mistake—so far as the jury was concerned—of concealing his crime and making a getaway under an assumed name, lying about what he knew to be the truth in connection with the death of the young girl whose body had by then been discovered. The jury may have felt, as common men and women, that conviction was the proper verdict by which to dispose of their responsibility.

Haigh committed precisely the same error after shooting his victim in the work-shed at Crawley. He could have gone straight to the police and said, " I don't know what came over me, but I found I had shot this woman. Will you come with me and I will explain what happened as far as I can," but he immediately took steps to conceal the body—and seal any more charitable view a lay jury might take of such a crime. He put the old lady into a forty-gallon steel drum, poured strong sulphuric acid over her and went off for a cup of tea, planning the disposal of her fur coat and jewellery.

Juries are strange, quixotic bodies and their views on arguments based on the McNaghten Rules may always be influenced to some extent by their plain, unvarnished commonsense. The law demands the kind of defence—for sane or insane—which is clearly defined in common words, and clearly put to them both by counsel and by the judge in his summing-up. They are seldom, in my experience, likely to be greatly affected by a firmament of medical stars or an outpouring of medical verbiage—however proper it may be. The jargon of psychiatry is particularly unintelligible to some. It is, to my mind, one of the great advantages of the jury system that after hearing all the evidence the jury is entitled to use their commonsense.

International Congress of Nurses in Sweden

AN Interim Congress was held in Stockholm, June 12th–16th to mark the 50th anniversary of the founding of the International Council of Nurses. Over 4,000 nurses from 35 countries met in Stockholm, the countries sending members for the first time were :—Italy, Southern Rhodesia, Korea and Turkey. Of the 800 members from Great Britain 31 were trainees of Guy's Hospital, a good number from one school. To house, feed and arrange for so many guests required most efficient organisation and we were well cared for during our stay. Hotel accommodation during June is limited and the majority of members stayed in the nurses' quarters in hospitals and in their blocks of flats.

On Sunday evening, special services were conducted in English in three of the great churches which were filled to capacity. An impressive feature of the service and in contrast to the beautiful vestments of the clergy was the candlelight procession of student nurses representing each of the nursing schools in Sweden. They processed with simple dignity towards the priests who placed the lighted candles on the altar. Flags, candles and song are important in the home and national life of Sweden—they were in evidence during the Congress. The silver birch tree too had its place of honour.

At the opening session on Monday, Princess Sybilla was present. Addresses of welcome were given by the Bishop of Stockholm, by a Member of Parliament, the Presidents of the State Medical Board and of the Medical Association. Miss Gerda Höjer, now a member of the Swedish Parliament and President of the International Council of Nurses presided at this session.

During the Congress papers were read by eminent members of the profession on : Medicine of To-morrow and the Position of the Nurse ; Training of the Nurse—Clinical Instruction ; The Increased Demand—how to meet it. At the last session Miss Marjorie Marriott (Matron of the Middlesex Hospital) presided.

The Congress was conducted in English, proceedings were formal, questions were handed in and many members (including the two delegates from the Guy's Hospital Nurses' League) stepped forward to the microphone. Many problems are similar in the different countries and it was interesting to hear the solutions suggested and the experiments which were being made, but amongst such a vast audience real discussion of the various subjects was not possible. Much discussion, however, took place after meals in St. Erik's mässan, the enormous canteen nearby and in the throngs waiting for the street-cars and elsewhere.

On Wednesday, visits were arranged to many different destinations, the party for Örebro starting by train at 6.55 hours and returning at 23.00 hours. There were as many as 400 in some parties. Our escorts wore the beautiful national costumes often lent for the occasion, and we had a wonderful day. One party, nine bus loads, travelled through beautiful scenery, skirting lakes with the mountains in the distance, to Mariefred, visiting a State sanatorium during the morning, Strängnäs Cathedral, Gripsholm Castle (now a State museum with its 2,000 pictures), the Folk School nearby for a wonderful meal, and on the return journey a lovely country house converted into a convalescent home for 30 patients. Here to our surprise and delight local singers entertained us for half an hour.

Music parties were arranged for the evenings following the formal sessions. A pageant play written by Elisabeth Dillner, Director of Nursing, Upsala University, was presented in English at the National Theatre by nurses and medical men. The scenes showed the growth of medicine and nursing from the Pools of Healing to the foundation of modern schools of training for nurses and midwives.

At Skansen, national park and museum, the last gathering of members was held amidst song and folk dancing. Alas ! rain, for the first time during the Congress, interfered with the proceedings.

Before and after the Congress many members attended courses and visited hospitals in Denmark, Finland and Norway before returning home.

We were envious of the spacious, well-kept hospitals, so beautifully clean and tended. In the Schools of Nursing in Sweden the Block System of training is used. The student nurses gain experience in four or sometimes seven different hospitals during the 3 $\frac{3}{12}$ or 3 $\frac{6}{12}$ years of training before registration. They usually specialise during the last year.

This movement from one hospital to another demands careful planning and correlation of work. Numbers are comparatively small; there are only 24 schools of nursing in Sweden. (Total population is seven millions). In spite of a general shortage of women power two independent schools of nursing, the Sophia Hemmet and the Red Cross (the first Red Cross school to be founded in the world), have waiting lists and are in a position to select their student nurses.

During the tour we met friends from other countries, discussed many problems, visited homes, institutions, factories and schools of nursing. We could not fail to be refreshed and stimulated by these contacts. Miss D. C. Bridges (Great Britain), Executive Secretary, in her paper on the history of the International Council of Nurses during 50 years had said to us, "the past is inspiring, the future challenging, the present is ours."

D.L.H.

Scandinavian Students at Guy's

From the 14th to the 25th July ten Scandinavian students, six Swedes and four Danes, were the guests of Guy's Hospital Dental Society. Some members of the Society were good enough to put them up in their own homes. A programme was arranged for them which included, apart from a tour of the hospital, attendance at lectures, operations, and of course a view of the television, together with a round of sightseeing. The visitors were especially interested in our use of general anæsthesia in dentistry which is less used in the Scandinavian countries than it is here. The operations they watched were :—an apicectomy under gas by Mr. Thompson, the removal of third molars in the theatre by Col. Kenshole, and a partial gastrectomy and a thyroidectomy by Mr. Slesinger on the television. They attended lectures by Prof. Thoma from America, Prof. Rushton and Dr. Marston.

Outside the hospital the party visited Messrs. Ash's factory to watch the manufacture of dental instruments and materials and were shown round the National Dental Hospital and the Queen Victoria Hospital, East Grinstead.

Leaving work behind they went to the G.P.O. at Mount Pleasant and were shown the intricacies of sorting and the Post Office Underground Railway. On Monday evening they went to a show at the Adelphi but perhaps their fullest day was Thursday. On that morning they went with their hosts on a trip to Windsor, being shown round the Castle privately by a very interesting guide, and in the evening they were entertained to dinner by Col. Kenshole. After dinner the president of the Malmo students made a charming speech of thanks and presented to the Dental Society their school crest, handmade in gold by one of the students—a very high honour which they have given only on two other occasions. They finished the evening watching the Ceremony of the Keys at the Tower. The party divided on Saturday, some of the students going over the Houses of Parliament and the others going down to Penshurst Place.

Although this was for most of the Scandinavians their first visit to England, they understood English well and were able to appreciate and enjoy lectures and the theatre and seemed very interested in all they were shown.

That they enjoyed their entire visit so much was due to the efforts of their hosts, and above all to Col. Kenshole. Not only did he and Mrs. Kenshole put up two of the Swedish students, but they also led the party in almost all its activities and helped the visitors in many other ways.

It is hoped to entertain another party of foreign students next year.

Guy's Diary

AUGUST

ACADEMIC AND SPORT

6th–13th. Cricket 1st XI. South Devon Tour.
8th. 3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
15th. 3.30. Dr. Barber and Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

The Steele Diaries—X

THE HOSPITAL (continued)

25th Augist, 1869.

To avoid any conflict or misunderstanding betwixt the House Physician and House Surgeon it is desirable that the following rules bearing on the duties of the House Physician should be officially notified :

That the House Physician shall give evidence in all Inquests and Courts of Law relative to cases that have been admitted to the Medical Wards of the Hospital.

That all cases of poisoning shall in future be admitted to the Medical Wards.

That in all cases brought in dead where there was reason to suppose that death was caused by internal organic disease the House Physician shall make the post-mortem examination and give evidence at the inquest.

These rules to take effect on the 1st of September.

6th April, 1870.

I have had to acknowledge during the week the receipt of 4 boxes containing addressed envelopes from Mrs. Ranyard of the London Female Mission for the use of the Medical Staff in the Out-patient room, with the object of providing the periodical visits of nurses to patients whom the medical officers might consider it advisable should have this attendance. The Staff generally hail this arrangement as a great boon and as likely to supplement the benefit to be derived from the treatment employed.

25th May, 1870.

A trial has been made of the brown bread made of the entire wheat, by issuing rations of the same to the patients in Stephen Ward. More than two-thirds of the patients have expressed their dislike to it and have asked to have it replaced with the ordinary white bread.

8th June, 1870.

Early on Friday morning considerable alarm was created in the Hospital by a fire which broke out in a bullding in the Queen's Head Inn Yard, used as a storehouse for paper shavings and abutting on the Hospital premises. The male servants resident in the Hospital were instrumental in extinguishing the fire and in preventing its extension, by having recourse to the water supply from the hydrant in the laundry yard in the immediate neighbourhood of the fire. A portion of the roof and wall of the storehouse fell upon the roof of the boiler house where the fragments still remain.

8th November, 1871.

At intervals during the week there has been a series of loud reports, resembling explosions in the hot water pipes in the basement of the old wing of Hunt's House. The engineer believes them to arise from some obstruction in the pipes.

31st January, 1872.

I had yesterday to acknowledge a gift of 20 brace of pheasants from H.M. The Queen.

28th February, 1872.

Yesterday being Thanksgiving Day for the recovery of the Prince of Wales, no out-patients were seen and no lectures were given in connection with the Medical School.

8th May, 1872.

Complaints have been made on several occasions and more frequently during the past week of some smells from Dr. Stevenson's laboratory. It would seem that some more effective means of carrying away the offensive effluvia from chemical operations were needed.

24th July, 1872.

The storm last night was much felt in the Hospital and torrents of rain came through the roof in several places especially in the Clinical Ward, in the New Kitchen, and in the Operating Theatre. The flooding of the Clinical Ward is of such common occurrence after a heavy rainfall that some means must be taken to prevent it in future.

12th February, 1873.

Two cases of preserved beef in tins were used yesterday for dinner in Samaritan Ward, instead of the ordinary fresh meat and were much approved of.

7th October, 1874.

At an inquest on a child who died from a scald, held at the Hospital last Monday, it came out that the mother had waited in the Surgery from 12 o'clock till 1.30 on the day the accident took place, Sunday, 27th September, without being seen by anyone, and also that when she brought the child to the Hospital to be admitted on Thursday last, she had to wait an hour before it was admitted.

30th December, 1874.

Great alarm was occasioned to the patients in Hunt's House on Monday last from a fire which broke out in a Hays warehouse facing the back of the Hospital in Maze Pond. Some of the patients suffering from bronchial affections suffered from the smoke caused by the fire at the time but as far as can be judged no permanent bad consequences appear to have arisen from it.

28th June, 1876.

Considerable curiosity and consternation were excited among numerous visitors last Sunday afternoon from the exposure of a corpse in the Catacomb underneath the Museum. The gratings for ventilating purposes placed in front of the catacomb are not sufficient to prevent people from seeing inside. Mr. Howse, who has chiefly to do with the embalming of the bodies, recommends that some glass louvres should be placed inside the gratings to prevent this.

19th June, 1878.

Two mistakes in the preparation of medicine have been reported to me as having occurred in Naaman Ward in the course of the week. The medicines referred to were prepared by the laboratory man who is occasionally employed to assist in dispensing and the mistakes were of a trivial character. It seems very necessary that some additional assistance should be afforded in the Pharmaceutical Department.

31st July, 1878.

I have to submit a letter from a Mr. Newcombe who is desirous of having a stall in the Out-patient Department to supply patients with drink and edibles during the long intervals they are commonly kept waiting for advice and medicines.

26th February, 1879.

There is some reason to suppose that the 2nd Dispenser, Mr. Wharton, notwithstanding his protestations to the contrary is still indulging in drink or narcotics.

Guy's and the Fourth International Congress of Otolaryngology, 1949

At the time of writing, the Fourth International Congress of Otolaryngology is in full spate. Last week the 1,304 delegates representative of 40 nations poured into London and to-day, the 24th July, the stream divides into three and flows in a rather more leisurely fashion towards Oxford, Cambridge and Edinburgh.

Guy's had an opportunity of welcoming a limited number of members on Tuesday, 19th July, and on Thursday, 21st July. On Tuesday they were offered a choice between viewing the Surgical Department's television or visiting the Throat and Ear Out-patients where a few cases of special interest had been assembled. The glamour of the television proved too much for most of them and only three faced up to the sterner stuff at Out-patients. After tea, two films were shown in the Anatomy Theatre, one by Mr. E. Gwynne-Evans concerned with the radiography of the sinuses and naso-pharynx in children and another by Professor Whillis, illustrating the movements of the tongue.

Both were received with great enthusiasm, Professor Whillis coming in for some extra applause for having torn himself away from the Primary Fellowship examination to arrive breathless just in time to present his film.

On Thursday there was the television again, and on Friday morning four visitors from Tunis departed from their programme and preferred seeing Guy's to the Combined Session on non-malignant strictures of the œsophagus at King's College.

It is understood that all who came were impressed by the able body of stewards and linguists whose chiefs kindly spared them from rounds and other duties to help with the arrangements.

Guy's and the Blue Stockings

The academic year just closing has seen the entrance of the first of the women students on their period of clinical studies. While it will be only correct for them to be proud of their position as the first women undergraduate clinical students at Guy's, it is desirable that they should not be led to over-estimate their historical importance. They are not the first women clinical students officially enrolled in Guy's Hospital Medical School. Women, admittedly post-graduate, but nevertheless students, were officially enrolled in the School for the Session 1890–91. They were Julia Maria Brinck and Margaret Mary Sharpe. Miss Brinck held the Irish Conjoint Qualification and Miss Sharpe the Scottish Triple. They came to Guy's to enter Dr. Savage's class in advanced Psychological Medicine in preparation for the M.D. degree. The lectures were in the Chemical Theatre and the demonstrations at the Bethlem Royal.

Whether these ladies were followed by others it is impossible to tell, as their formal admission to classes in the School was not universally approved, and it was decided that in future years, although women might attend Dr. Savage's class, they should do so as his private pupils and not as students entered on the School roll, paying fees through the School.

We have not followed completely the careers of these two students, but Dr. Brinck certainly obtained her M.D., in the University of Berne in 1887.

Reviews

Aids to the Nursing of Venereal Diseases. By E. M. RYLE-HORWOOD. Bailliere, Tindall & Cox. *Price* 5*s.*

Sooner or later during training every nurse meets with a case of venereal disease, often that of one of the later manifestations in a medical ward, an expectant mother in the latent stage, or a case of early venereal disease in a casualty department. A little patchy knowledge is thus gained, but the nurse in training has little opportunity of acquiring a comprehensive picture of the natural course of these diseases, unless she spends part of her training working in a venereal disease clinic. Medical text-books are usually far too full of detail to be of value and contain little or nothing on the nursing aspects.

This small volume contains an admirable short account of the course, methods of investigation and modern treatment of these diseases. Constructed from the daily work by a busy V.D. clinic, it approaches the problems involved from a practical and instructive angle which includes the medical, nursing, social, public health and confidential aspects. The work is clearly and concisely written, is well balanced and notably free from errors. There is some confusion in the presentation of the description of congenital syphilis where the paragraph outlining the late manifestations is sub-titled " Early Congenital Syphilis " and a description of the early lesions is missing.

The book can be safely recommended as accurate and helpful to the nurse in training. It is written, however, almost exclusively from the outlook of and for the benefit of the female nurse and to render it of equal value to the male nurse some details of the procedure of urethral irrigation, preparation for urethroscopy, care and maintenance of urethral bougies, and the local treatment of such conditions as balanitis, soft sore, bubo, epididymitis and prostatitis should be included.

V.E.L.

Modern Discoveries in Medical Psychology. By CLIFFORD ALLEN. 2nd Edn. Macmillan. *Price* 12*s.* 6*d.*

In this book Dr. Allen has provided an outline, simply and directly written, of the doctrines of some of the outstanding figures in the history of psychological medicine. A chapter each is devoted to Mesmer, Janet, Morton Prince, Jung and Adler; two chapters to Freud. The work of Kretschmer and of Pavlov is briefly discussed. An account of the principal methods of physical treatment is given. The phrase " Modern Discoveries " in the title is interpreted liberally; there is no acknowledgment of the work done over the last three decades in exploration of the field of psycho-physical relations.

D.O'N.

Correspondence

Reports upon Games

SIR,—It has given me great pleasure to read Dr. Stewart Wacher's letter in the current issue of the *Guy's Gazette*, especially as I take him to be a son of my old friend, Dr. Sidney Wacher. He has written very quietly and restrainedly and with every statement he has made I thoroughly agree. The facts that as yet we subscribers have never been informed who is captain of Guy's cricket team, or the name of the secretary this year, let alone the names of the members of the team and only the results of ordinary matches, must be recorded as sins of omission against the secretary or captain of the cricket team. Personally, I feel perfectly certain no blame can be attached to the Editor of the *Gazette* : had he been handed the information he would certainly have published it at the first opportunity.

It seems to me obvious that neither Guy's nor the United Hospitals have any rules or regulations, certainly applying to cup-ties ; and if organisation is not established surely chaos must result.

Hearing Mr. P. Russell is captain of Guy's this year and secretary of the United Hospitals, thinking it a golden opportunity, I wrote to him privately, making a suggestion, the carrying out of which would, I feel sure, benefit the United Hospitals and keep Guy's in the forefront as the leading hospital. Though I have had no reply yet, I hope he is giving the matter his consideration. I consider the time has now come to let subscribers to the *Gazette* and old sportsmen know my suggestion. I think I ought to state that from 1886 I played for Guy's for 10 years (five cup-ties) : from the same date for the United Hospitals, captaining them many times and was one of Guy's two representatives on the United Hospitals' Board for years. The statement has been purely made to prove to the present generation I have not made my suggestion without sound knowledge of its benefit. Briefly my suggestion to Mr. P. Russell was that he should call a meeting of the United Hospitals at Guy's, each hospital to send two representatives.

AGENDA.

1. To draw up Rules for the Inter-Hospital Cup-Ties. (N.B.—Having a draft, with which I offered to help him, read for consideration).
2. To draw Cup-Ties.
3. To elect United Hospitals' team.

In olden days, early in April, the secretary called such a meeting, which two representatives of each hospital attended. At that meeting the draw for the cup-ties was made, dates and grounds arranged for play, even the dates for the final fixed, always on a neutral ground, *e.g.* Richmond. Any team not prepared to take the field by 11.15 or certainly 11.30 was automatically scratched. In the case of a ground pronounced unfit for play owing to weather conditions by the umpires, the captains must there and then fix another date as soon as possible for the match to be replayed.

The cup-ties matter settled, about 16 men were selected from various hospitals : batsmen, bowlers, wicketkeepers, with a captain and vice-captain to represent the United Hospitals during the season.

It seems to me, if my suggestion was carried out, it would benefit the hospitals by rules, enable all details of cup-ties to be published, and benefit subscribers to the *Gazette*.

Apparently there is no member of the Guy's staff with sufficient interest in sport who would make an effort—"to maintain the proud position in sport, which it (Guy's) has held for so many years " (to quote Dr. Wacher).

From personal experience, I can say that Sir Frederick Taylor (when Dean), Sir Cooper-Perry, Dr. Lauriston Shaw or Herbert Durham (Editor, *Gazette*) never missed anything, even in sport, to maintain Guy's reputation. When I was secretary and vice-captain at Guy's, I was often astonished at their keenness and knowledge of Guy's cricket. I had many happy talks with them all and very sound advice.

Yours, etc.,

I. H. BUSTEED.

" Balgores,"
31, Glenleigh Avenue,
Bexhill-on-Sea.

A Letter from the Atlantic

SIR,—You tell me—May 7th—I must write and let you know how I am getting on and what I am thinking about. Well! my life is that of the ever-varied monotony of the sea; and the sea, like the desert, makes men think. And then—May 21st—you give me food for thought. I did not criticise the subject of "medical illustration" as a means of education. I revolted against "Education by Terror." Complaint had been laid against the second part of my letter—*Lancet*, May 7th—in which I made this revolt. It was said not to be understandable. I can well believe that. I did not understand it myself. I was groping after that new mode of rule that must be evolved for institutions such as Guy's in a new work with new principles.

May we not have ideas half-formed within our minds, that we cannot express, because we cannot formulate them enough to put them into words? And shall we not try to do so? Having done so, shall we not publish them in hope that some other mind has had similar ideas and can receive them? And then one day comes enlightenment and you see clearly what before was not understandable. That is what has happened to me, through Bertrand Russell (Vide: "Authority and the Individual") and the Atlantic.

First about Fears (p. 991). There are three of them. First, fears from within. These are the ones that may be liars. They must at all times be faced. They then go, become smaller, or, at least, less unbearable. Then there is fear deliberately chosen. This is good for us all in moderation. Finally, fear forced on us from without. This is terror. When we are the victims it is hard to struggle against it. We must therefore hold out a helping hand to all those upon whom it is being forced. In this it is always our job to interfere. That has been our business for the last ten years or more.

Once upon a time a benevolent autocracy was thought to be the best form of government of a hospital, a college, or a school, and so at times it was. But benevolent autocrats are so hard to find and malevolent ones do so much harm we dare not trust them. There must be found another form of rule to replace it. It seems we are trying out committee rule to-day, but still we have to keep responsibility for the man at the head of each department with the chain of responsibility intact from him down to his junior underling. It is "Authority and the Individual" working in a small unit instead of the whole race of men.

Now it seems almost to be a rule that a committee is governed by the worst-ever of the members in it; or is guided by an influential member who on a single point is below his own standard in the general way. We need to guard against this; and to suffuse throughout the institution the highest without saying what it is or putting it down in the form of resolutions.

For instance, would anyone vote for the following pious resolution: "Fear forced upon women and children is a proper way in which to compel them to your will. It should therefore be used throughout the hospital, become a part of health education, and be taught to all students—medical, dental, nursing, radiographic, and electro-therapeutic; as well as massage and paediatric." Of course they would not. They would answer it with the motto of the Boro's old school tie, "Yer can't do that there 'ere."

Yours, etc.,

T. B. LAYTON.

"The Endocrines."

SIR,—I seem to detect an increasing tendency to refer to "the endocrines." The word "endocrine" is certainly an adjective, though the stricter but less euphonious word should be "endocrinological"—thus: "This endocrine nonsense—" or the more tongue-twisting "An endocrinological hypothesis—." It may possibly be an adverb—thus: "The cause of her trouble is undoubtedly endocrine." In addition there are two nouns: "endocrinology"—thus: "The Journal of Endocrinology" and "endocrinologist"—thus: "so-and-so is an endocrinologist." But pray let us defend ourselves against the third noun, which has occasionally been used in the singular—thus: "The endocrine used for this condition is testosterone"; or more usually in the plural—thus: "The Effect of Endocrines on Fibro-adenosis," or "Endocrines and Lactation." Surely the surgeon would agree with me in deploring such a title as "The Role of Surgicals in Carcinoma of the Breast," and the gynæcologist would be equally outraged if I wrote an article on "The Gynæcologicals (or perhaps it might be more euphonious to say "the Gynæcals") in the Treatment of Functional Uterine Hæmorrhage."

Yours, etc.,

122, Harley Street, W.1. P. M. F. BISHOP.

Sport

SAILING

The Ogilvie Cup

Racing for the Ogilvie Cup took place at Burnham-on-Crouch last Friday, after a lapse of eleven years. Although the sun was blazing the wind strength for the most part varied between a flat calm and dead calm, with an occasional catspaw in time to save the crew from mutinying and diving overboard for a bathe. There was an exception to this when one skipper was unable to dissuade the good fellow from his intentions.

John Lindsay, in *Crysolite*, led at the ragged, running start. After about 800 yards, however, the wind changed through 180°, and the dinghies were now beating up to the first mark, the Branklet buoy. John Bradbeer, in *Garnet*, and Russell Rees in *Jet*, led the fleet round Branklet into the River Roach, taking the West bank. The other boats sailed close-hauled up the East shore, and beat the Westerners to the Roach buoy.

Donald Longmore, in *Topaz*, looked all set for first place on the reach out of the Roach, but ran into a calm patch and allowed the rest of fleet to catch up with him. In the Crouch once more the next mark was Red Holliwell on the north shore. *Crysolite* and Crispin Kendall in *Amber* crossed to the north bank, intending to beat up to the mark in slack water, a good move had there been any wind, but one which, under the circumstances, put them 10 minutes behind everyone else for the rest of the race. Meanwhile, Alan Blower in *Sapphire*, who had been maintaining a confident and steady seventh, found a gale of his own which he kept exclusively to himself. He now swept through the fleet round Red Holliwell and home to win the Ogilvie Cup for 1949, three minutes ahead of anyone else.

Results.

1st.—*Sapphire*: A. Blower and J. N. Pachmayr.

2nd.—*Tourmaline*: R. Harper and C. Walker.

3rd.—*Topaz*: D. Longmore and M. Awty.

4th.—*Garnet*: J. Bradbeer and P. Tatford.

5th.—*Jet*: R. Rees and S. Paget.

6th.—*Crysolite*: J. Lindsay and J. Jemson.

7th.—*Amber*: J. C. Kendall and J. Goodfellow.

THE ATHLETIC SPORTS

After a ten-year break the Sports were revived at Honor Oak Park on Wednesday, 13th July. Despite the threatening weather there were over three hundred spectators and thirty-nine competitors, apart from those in the relays and invitation events.

Mr. J. S. Batchelor was President of the Sports and Referee and Mr. J. H. E. Winston acted as Announcer and Recorder. The judges were Mr. A. Albers, Mr. H. Brunow, Dr. K. Palmer and Dr. I. Evans, and Messrs. G. A. R. Winston, H. A. Hughes and R. W. Stanford officiated as timekeepers. During the sports a few side-shows were run by individual clubs, and teas and refreshments were served in the pavilion.

The first event was delayed by a slight shower but after this the weather remained cloudy and pleasantly cool until just before the finish. Then a heavy downpour washed out the markings but was not sufficient to dampen the grim determination of the finalists in the Inter-Clubs' relay. They were partly rewarded by the fact that some of the officials had to stay out in it too.

A long programme had been arranged with a total of 29 events, heats being held on the day. The standard of the results was, on the whole, not high, but E. N. McKenzie set up a new record for the 880 yards by recording a time of 2 mins. 4.2 seconds. He later won the 220 yards. Worthy of mention also were the 100 yards, won by T. G. Thomas in 10.4 secs. and the Ladies' 80 yards which was taken by Miss Denny in 10.6 seconds.

The invitation events created a great deal of interest. Most notable was the Invitation Mile which was run in a very fast time and provided a thrilling tussle at the finish between Eric Dormer of St. Bart's. Hospital and Len Marchant of the Belgrave Harriers. Another thrilling race was the Inter-Hospital Medley Mile Relay. Competitors were St. Mary's, St. Bart's, St. Thomas', Middlesex and Westminster Hospitals. Each team entered four competitors who ran 880 yards, 220 yards, 220 yards and 440 yards in that order. At the last 440 yards, John Mark of St. Mary's was leading but was being inexorably overhauled by Arthur Wint of St. Bart's. who had been third at the change-over. To the consternation

and regret of everybody, however, Wint pulled a muscle in his thigh and had to retire from the race. After that there was nobody to challenge Mark who came in an easy first.

The Basket Race, put on by the Borough Market Sports Club, was watched with alternate amusement and admiration. Many competitors failed to raise their 10 baskets and the crashing piles without doubt delayed many others. Some starters seemed to find it necessary to run frantically backwards and this provided them with a handicap from which they never fully recovered. Others just stood balancing their baskets. The Sack Race proved a very popular counter-attraction to their last heat, but the final of the Basket Race came into its own again with an amazing 10-yard dash at the finish, both leading competitors going all out—no-handed, too.

The mixed 3-legged provided another amusing interlude, but the funniest event of all was the Tug-of-War. A team from the "M." Division, Metropolitan Police, having pleaded (over the 'phone) their inexperience and inaptitude scattered all-comers with one, well-co-ordinated pull. However, they were finally defeated by a huge crowd of Dentals who outnumbered the police by more than 3 to 1. Even this was a struggle.

There was a fine display of prizes and these were presented at 6.30 p.m. by Mrs. W. D. Doherty, who had very kindly consented to perform this task. Mrs. Doherty was herself presented with a large bouquet of flowers and was sincerely thanked by Mr. Batchelor who also made some pertinent remarks about the sports. Mrs. Doherty was later cheered heartily by everyone present at the prize-giving.

In the evening an informal dance was held in the pavilion. An extension of licence to sell drinks at the bar had been granted until 11 p.m. The dance ended at 11 p.m.

RESULTS.

100 yds.—T. G. Thomas, B. M. Gray, T. G. Bellis, 10.4 secs.
220 yds.—E. McKenzie, T. G. Thomas, H. Hughes, 23.4 secs.
440 yds.—H. St. John, J. Comper, K. Bender, 57.8 secs.
880 yds.—E. McKenzie, J. Lewis, D. Fawkner, 2 min. 4.2 secs. (record).
1 Mile—D. Fawkner, D. Griffith, G. Moore, 5 min. 18.6 secs.
3 Miles—B. Hartley, M. Strelling, 16 min. 36.4 secs.
Weight—B. M. Gray (35 ft. 7½ ins.), A. A. Roe (34 ft. 5 ins.), E. A. Murray (32 ft. 8 ins.).
Discus—H. Ohlrich (98 ft. 5 ins.), D. Le Clus (85 ft. 4 ins.), G. A. E. Baker (72 ft. 7 ins.).
Javelin—D. Le Clus (113 ft. 5 ins.), V. Bartley (110 ft. 4 ins.), R. Bret-Day (70 ft. 6 ins.).
Long Jump—D. Le Clus (20 ft. 7 ins.), T. G. Thomas (20 ft. 1 in.), J. Lewis (18 ft. 1 in.).
High Jump—T. G. Thomas (5 ft. 4 ins.), I. Scott (5 ft. 1 in.), D. Le Clus (5 ft. 0 ins.).
120 yds. Hurdles—I. Evans (7 hurdles only), B. Hartley (8 hurdles only), B. G. B. Christie (10 hurdles), 19.2 secs.
Ladies' 80 yds.—Miss Denny, Miss Deering, Miss Flavelle, 10.6 secs.
Sack Race—J. Leckie, T. G. Bellis, G. Clarke.
Mixed 3-Legged—D. Sturdy and Miss Cummings, W. Tweed and Miss Gow.
Employees 440 yds.—A. Blair, B. Jeans, R. Chumbley, 59.6 secs.
Children's Race—Maureen Roe, Maureen Stuart, Rosemary Lewis.
Basket Race—Hardy, Turner, Drapper, 1 min. 41 secs.
Invitation Mile—A. E. Dormer (St. Bart's), L. Marchant (Belgrave Harriers), R. Bedford (Belgrave Harriers), P. Gigg (Imperial College), 4 min. 23.6 secs.
Inter-Hospital Relay—St. Mary's (G. Ridell, J. J. Brown, Pooler, J. Mark). Middlesex, St. Thomas'.
Ladies' Relay—Radiographers B. (Misses Flavelle, Bucknall, Deering and McDougall), Physiotherapists A., Physiotherapists B., Radiographers A., Students.
Inter-Clubs' Relay—Rugby Club (B. Gray, T. G. Thomas, K. Heber, E. Williams), Hockey Club, Soccer Club.
Tug-of-War—Metropolitan Police (M. Div.), Dentals.
Winner of Clement-Lucas Cup for best performance, T. G. Thomas, 16 points.
Runner-up, D. Le Clus, 14 points.

G. A. E. Baker represented Guy's in the United Hospitals' team which ran against the Crusaders in Dublin on July 19th and against South Wales at Port Talbot on July 23rd.

CRICKET

1st XI. *v.* Private Banks

July 16th, 1949.
at Catford Bridge. Result—Lost.
Guy's 88; Private Banks 89—6.

1st XI. *v.* Old Whitgiftians

July 23rd, 1949.
at South Croydon. Result—Lost.
Old Whitgiftians 237; Guy's 87.

1st XI. *v.* The Tramps

July 24th, 1949.
at H.O.P. Result—Won.
Guy's 122; The Tramps 117

Many Guy's men will join with the Cricket Club in congratulating D. E. Blake, our wicket-keeper and opening bat, on his recent selection to play for Hampshire when they played Combined Services. His performance in this match, contributing 47 and 54 and distinguishing himself behind the stumps, has led to an invitation to play in several more matches, including those against Middlesex, Gloucester and Kent.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1.

Applications are invited for the post of **Trainee Registrar to the Diagnostic X-ray Department** from those who have held the appointment of Medical or Surgical Registrar. Applicants must hold a higher medical or surgical qualification, and will be expected to take the course of the Diploma of Medical Radiology. The appointment will be for two years from 1st October, 1949. Forms of application are obtainable from the Medical School Office and should be forwarded to the Dean not later than 26th August, 1949. Salary at the rate of £650 per annum.

PLYMOUTH SPECIAL HOSPITAL MANAGEMENT COMMITTEE

The Isolation Hospital, Beacon Park Road, Plymouth.

Resident Assistant Medical Officer (B.1.)
(Male. Unmarried)

Applications are invited for the above whole-time appointment. The duties are chiefly in connection with fevers, venereal diseases and early tuberculosis, and applicants should be able to drive a car.

Salary £500 per annum together with full residential emoluments. Previous general hospital house appointments essential.

The appointment will be for a period of six months in the first instance, mutually renewable for a further six months, subject to any alterations of salary and conditions which may be in force at that time. Appointment is terminable by one month's notice on either side.

Applications from practitioners holding B.1. appointments cannot be considered unless ineligible for H.M.Forces.

Applications should be sent to the Medical Superintendent, at the above address, as soon as possible, enclosing copies of two recent testimonials.

CONVALESCENT MEASLES SERUM

The Hospital is finding it difficult to maintain an adequate supply of Convalescent Measles Serum. Donations of about 6–8 ounces of blood from anyone who has recently had measles would be greatly appreciated. Volunteers should report to Dr. F. A. Knott, Dept. of Clinical Pathology.

JUNIOR STAFF APPOINTMENTS

The following recommendations for appointments and reappointments have been made. Formal notices of appointment will be sent after confirmation by the Board of Governors of the Hospital, which will meet next on September 5th, 1949. Unless otherwise stated, all appointments will commence on October 1st, 1949.

W. D. DOHERTY,
Superintendent.

Medical Registrars.
Dr. A. Batty Shaw, appointment for two years.
Dr. W. D. Brinton, reappointment for one year.
Dr. T. M. L. Price, reappointment for one year.
Dr. J. R. Trounce, reappointment for one year.

Surgical Registrars.
Mr. P. G. Large, appointment for two years.
Mr. D. J. Tibbs, appointment for two years.
Mr. R. N. Ticehurst, appointment for two years.

Casualty Surgeon.
Mr. P. W. Clarkson, reappointment for one year.

Anæsthetic Registrar.
Mr. D. M. Carnegie, reappointment for one year.

Obstetric and Gynæcological Registrar.
Mr. H. A. Ripman, reappointment for one year.

Ophthalmic Registrar (Part-time).
Mr. W. E. S. Bain, appointment for the period July 15th, 1949, to September 30th, 1951.
Mr. P. A. Gardiner, reappointment for one year.
Mr. D. Shorten, reappointment for one year.

Dermatological Registrar.
Dr. P. A. J. Smith, appointment for the period July 5th, 1949, to September 30th, 1950.

Registrar to the Department of Diagnostic Radiology.
Dr. E. G. Redman, reappointment for one year.

Neurological Registrar.
Dr. M. J. Parsonage, reappointment for one year.

Orthopædic Registrar (Whole-time).
Mr. A. J. Drew, appointment for one year.

Registrar to the Cardiac Department (Part-time).
Dr. G. J. L. Reynolds, reappointment for one year.

Registrar to the Endocrine and B.M.R. Departments (Part-time).
Dr. R. R. de Mowbray, appointment for one year.

Registrar to the Genito-Urinary Department.
Mr. R. E. Horton, appointment for one year.

Registrar to the Physiotherapy Department (Whole-time).
Mr. K. W. N. Palmer, reappointment for one year.

Registrar to the Physiotherapy Department (Part-time).
Mr. H. T. van Diggelen, reappointment for one year.

Pædiatric Registrar.
Dr. L. G. Scott, reappointment for one year.

Registrars to the Throat and Ear Department (Part-time).
Mr. C.N. d'E. Eastes, reappointment for one year.
Mr. K. L. Wilson, reappointment for one year.

Hæmatological Registrar.
Dr. F. G. Stoddart, reappointment for one year.

Medical Registrar to the Evelina Hospital.
Dr. J. K. Martin, reappointment for one year.

Registrar to the Ear, Nose and Throat Department of the Evelina Hospital (Part-time).
Mr. C. N. d'E. Eastes, reappointment for one year.

Assistant Director of the V.D. Department.
Dr. Jean H. Morton, reappointment for one year.

Medical Officers to the V.D. Department.
Dr. Joan Halstead, reappointment for one year.
Dr. Christine M. Stacey, reappointment for one year.
Dr. J. R. D. Williams, reappointment for one year.

Chief Assistant in the Department of Clinical Pathology.
Dr. B. J. Stephens, reappointment for one year.

Assistant Clinical Pathologists.
Dr. H. Greenburgh, reappointment for one year.
Dr. D. R. C. Willcox, reappointment for one year.

Chief Assistant to the Department of Psychological Medicine.
Dr. D. O'Neill, appointment for the period July 7th, 1949, to September 30th, 1950.

Registrar in the Dental Department for Children.
Mr. M. A. Kettle, reappointment for one year—3 sessions per week.
Mr. H. Richards, reappointment for one year—3 sessions per week.

Administrative Dental Officer.
Mr. R. E. Matthews, reappointment for one year.

Assistant Clinical Pathologist—Dental.
Dr. C. W. T. Shuttleworth, reappointment for one year.

Dental Anæsthetist to Salomons Welfare Centre.
Dr. E. H. Rink, reappointment for one year.

Dental Officer to Salomons Welfare Centre.
Mr. E. A. Lloyd, reappointment for one year.

Orthodontic Assistants.
Mr. E. K. Breakspear, reappointment for one year.
Mr. T. P. Parr, reappointment for one year.
Mr. S. B. Taylor, appointment for one year.

APPOINTMENTS

UNIVERSITY OF LONDON

The following are included in the appointments as representatives of the University on the Councils of the Medical Schools indicated in parenthesis.

Sir Herbert Lightfoot Eason (Guy's Hospital Medical School).

Mr. E. G. Slesinger (St. George's Hospital Medical School).

Prof. T. B. Johnston (St. Thomas's Hospital Medical School).

Teachers.

The following have been recognised as Teachers of the University in the subject indicated in parenthesis.

R. E. Rix, F.D.S., and F. S. Warner, F.D.S. (Dental Surgery).

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Mr. J. E. Piercey has been elected Hunterian Professor, his subject being "Safety in Surgery of the Thyroid."

ROYAL FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW

R. E. Rix, F.D.S., has been appointed examiner for the Diploma of Dental Orthopædics, Part B. Dental Orthopædia.

PASS LIST

UNIVERSITY OF LONDON

M.S.

Branch IV.—Otology, Rhinology and Laryngology.

July, 1949.

L. F. W. Salmon.

Ph.D.

W. J. R. Calvert.

ACADEMIC POST-GRADUATE DIPLOMA IN PUBLIC HEALTH.

June, 1949.

R. F. Barclay C. L. E. H. Sharp

ACADEMIC POST-GRADUATE DIPLOMA IN BACTERIOLOGY.

F. L. Jackson.

CAMBRIDGE UNIVERSITY

FINAL M.B. EXAMINATION.

Easter Term.

Part II.—Principles and Practice of Physic, Pathology and Pharmacology.

C. C. Clapham I. P. James
A. Gol J. F. Soothill

SOCIETY OF APOTHECARIES OF LONDON

PRIMARY EXAMINATION.

July, 1949.

Physiology : C. O. Bedell, R. M. Saldanha.

CONJOINT BOARD

D.L.O.

C. N. d'E. Eastes J. T. M. C. Jenkins

L.R.C.P., M.R.C.S.

FINAL EXAMINATION.

July, 1949.

Pathology.

D. H. le Clus T. M. Owen
L. G. Crouch J. B. Parsons
J. Foley J. A. Payne
H. R. E. Gillespie E. N. Plomer
R. Goulding *H. Schlossmann
J. L. Harrington L. Tann
G. L. Jones W. H. Watson
E. T. King R. I. J. Williams
D. Lennie

Medicine.

D. Barker *D. G. May
J. E. Breese *Q. F. Neethling
D. W. A. Drew A. M. Platt
C. J. Frederick *H. Schlossmann
*K. M. Herd *O. L. Thomas
S. F. Knipe P. A. Van der Merwe
D. M. Lewis

Surgery.

B. L. Bisley *D. G. May
*J. E. Breese *Q. F. Neethling
G. Canty M. Rayne
I. B. Davies K. F. Robinson
H. R. E. Gillespie *H. Schlossmann
*S. S. Grové B. L. Whitaker
T. C. Hopkins-Husson R. H. R. White
*I. Kent

Midwifery.

J. F. le Clus P. W. Ruggles
G. Holden *H. Schlossmann
E. T. J. Jones I. M. Sharpe
M. J. Hunter P. R. Sowerby
P. H. Kendall D. E. Sturdy
D. M. Lewis M. G. Thompson
I. J. MacQueen P. J. Wardell
J. B. Parsons W. N. Whamond
D. F. Potter B. L. Whitaker
R. J. Powell

*Have completed the examination.

GUY'S HOSPITAL LADIES' ASSOCIATION

The Derry Roof Gardens (Derry & Toms, Ltd.), High Street, Kensington, W.8, will be opened by the Lady Ebbisham, M.B.E., in aid of the Guy's Hospital Ladies' Association Comforts Fund, on Monday, August 15th, at 3.30 p.m. The Gardens will be open for this Fund until Saturday, August 20th, daily 9 a.m.—5 p.m. Saturday 9 a.m.—1 p.m.

As many visitors as possible are invited to help the funds during this week.

CHANGES OF ADDRESS

W. M. Dixon, M.B., B.S., Red Cross Sanatoria of Scotland, Tor-na-Dee, Milltimber, Aberdeenshire.

S. A. Marsh, M.R.C.S., L.R.C.P., Brendon, Ightham, nr. Sevenoaks, Kent. (Tel. : Borough Green 378.)

R. G. Walton, M.B., B.S., General Hospital, Vancouver, B.C., Canada.

BIRTHS

MARSH.—On July 5th, 1949, to Molly (née Moon), wife of Stewart Anthony Marsh—a son (Richard).

PETT.—On July 12th, 1949, at Whitehaven, The Drive, Hove, to Margaret (née Miller), wife of Basil W. Pett, B.D.S.—a son.

PLATTS.—On June 24th, 1949, at Tripoli, Lebanon, to Patricia (née Davys), wife of Peter M. Platts—a son (Anthony Peter).

Eds. { H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

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PASSIM

APPOINTMENTS vacant: a general surgeon "candidates must be Fellows of the Royal College of Surgeons of England," a consultant venereologist "candidates must produce the degree of M.D. of a university of the British Empire," a psychiatrist "applicants must possess the D.P.M.," a physiotherapist "holding qualification of the Chartered Society of Physiotherapy," planning associates "candidates should be university honours graduates," a cook-supervisor "preference will be given to candidates holding a diploma." And it is an accepted condition nowadays that to become an office boy, a keeper of stamp-books, a poster of letters and a fetcher of tea, a school certificate or its equivalent must be produced while, in Buenos Aires, even writers must be recognised as "registered intellectuals." With apologies to the proprietors of the "Lancet" and the "Times" we nevertheless have no qualms about lifting extracts from their advertisement columns if only to illustrate that it is a qualification-ridden age in which we live.

On the one hand is a fanatical striving for equality, a policy which will allot comparable wages to men and women with, at the same time, utter disregard for their respective social responsibilities, which will give similar opportunities to women in the professions without pausing to consider their particular attributes and which lays down exacting and inviolable conditions of employment for different types of workers whilst setting aside the fact that circumstances vary up and down the country. Meantime, a vast hierarchy is being created in which the distinctions are based almost exclusively upon academic accomplishment.

Wells, in his lunar novel, conceived a society with the different members trained to their definite jobs from birth. At this idea the reader laughed, or even recoiled. But what about the state of affairs that prevails today? So intensive and prolonged is the initiation to the careers that almost from the cradle the inevitably precocious child must make his choice of life and livelihood and then, over the succeeding years, devote himself to his learning and tests until eventually, with an appropriate tag, he is judged as fit by his confrères to join the practising body.

Orthodoxy thus rules, individuality is stultified, academic prowess is the key to success and, in so many walks of life personality, resourcefulness and natural ability count for nought. No longer is the being drawn to the vocation; instead he is directed by the forces of society into a particular form of employment according to the scholastic standards he is capable of achieving in that field.

No one, surely, believes that this makes for the best use of the brains, abilities and propensities of the various characters comprising the race. Some measure of grading is admittedly desirable, but to attempt this by examination alone is to be satisfied with the imperfect. Some among those who offer patronage to the aspiring are obviously concerning themselves in this matter. Selection committees of medical schools accept that entrance competitions have limited application, some business firms still give preference to the man rather than his diplomas and even the civil service experimented with Stoke d'Abernon. The danger, nevertheless, is great, especially in any vast organisaton in which the terms of service for all are prescribed and, even more, when members of the laity can express a preference, for they are apt to be blinded by a string of letters or degrees.

"The time has come, the Walrus said, to talk of many things." The time has come for man, it seems, to take stock of his position. Even yet, the education system is not what it should be. Perhaps, indeed, it is too "systematised" and we have lost that knack of what Maillaud described as the training of character rather than intellect. At any rate, if originality, flair and initiative are to be given their full scope the examination standards must be more sensibly applied—to judge by the recent pronouncements on the "membership" the physicians are already mindful of this—the existing pre-occupation with formal qualification must be abandoned and the warning of Hazlitt that "learning is the knowledge of that which none but the learned know" must ever be kept in mind.

The transatlantic traffic still flourishes. At the beginning of September Dr. Baker, the Sub-Dean of the Medical School and Assistant Physician to the Cardiac Department, leaves for the United States and Canada. He will be away for about three months visiting hospitals and clinics throughout the North American continent. Confirmation has not been given to the rumour that besides broadening his already extensive medical experience he will add to his enjoyment and collection of modern art. Nor is it known whether he intends to take up baseball after scoring 95 runs against the Medical School Staff in the cricket match held the other week.

Guy's representatives in the Clothworkers' Company Exchange Scheme with Johns Hopkins are soon to depart. Mr. Blaikley leaves at the end of September and, besides Baltimore, he hopes to see Boston as well. Mr. Brock, who goes about the middle of October, will be away for a month.

Professor Stead has now returned from the West Indies whither he travelled to act as an external examiner at the newly founded university there. He has promised an account of his experiences which we look forward to publishing in the *Gazette*.

For the second year in succession the Department of Child Health is offering hospitality to medical students from Duke University, North Carolina. Four of them are here for three months and two more are at Bart's. The study and ward work done in this country is regarded by their own university as an approved course in pædiatrics prior to their qualification in December.

A welcome is extended to Dr. Robert Knox on his appointment to the Chair of Bacteriology at Guy's, to date from 1st October next. The son of a radiologist, he went to school at Highgate, was a classical scholar at Balliol, took a "first" at Oxford and was cox of the university boat in 1925. Starting on a medical course at Bart's. in 1926 he qualified M.B., B.S., in 1932, took his M.R.C.P. and M.D. in 1934, his M.A. Cambridge in 1935 and M.A. Oxford in 1945.

After working with Lord Horder at Bart's. he was a research assistant at the London School of Hygiene, interesting himself there in studies of bacterial respiration. Subsequently he was demonstrator of pathology at Cambridge, a member of the scientific staff of the Imperial Cancer Research Fund, Director of the Public Health Laboratory, Leicester and, later, in a similar position at Oxford. His published papers have been numerous, many of them devoted to the metabolic problems of bacteria.

From September 27th-30th the British Rheumatic Association is staging an exhibition at the Town Hall, Chelsea. Specially designed mechanical equipment will be on show and in operation, demonstrations will be arranged by the Disablement Section of the Ministry of Labour, by "Remploy," and by voluntary organisations concerned with training and work for the disabled, and various therapeutic appliances will be exhibited. A two-day conference is being held concurrently and of this further particulars can be obtained from the B.R.A., 5, Tite Street, S.W.3. (Flaxman 2957).

The small size of the present *Gazette* is regretted but is none the less deliberate. An increased paper allocation has allowed for a wider circulation, already announced, and, throughout the course of the year, more pages on an average per issue. During August, however, the size has been limited in order to allow of bulkier numbers later in the year.

"Compound E"

A Clinical Lecture delivered at Guy's Hospital on Friday, July 29th, 1949, by P. M. F. BISHOP, D.M.Oxon.

LADIES AND GENTLEMEN,—It was Professor Dodds[1] in the course of the First Addison Lecture who likened the events leading up to a scientific discovery to a man in a dark room scrambling for the switch and tripping over the furniture; when he has once found the switch and turned on the light he can arrange the furniture in an orderly manner. In *The Times* of April 23rd, just over three months ago, ther was a short column announcing the treatment of a small series of cases of rheumatoid arthritis with "Compound E," with spectacular results. Someone had found the switch.

History of the Discovery of the Effect of "Compound E" on Rheumatoid Arthritis

First let me trace the events which led up to that announcement. Philip Hench[2] of the Mayo Clinic, in his Heberden Lecture in this country last year, expressed his belief in the potential reversibility of rheumatoid arthritis, pointing out that the condition had been known to undergo marked remission during an attack of jaundice and in pregnancy. Indeed, from time to time physicians, struck with the improvement that occurs during pregnancy, have used sex hormones, gonadotrophins and blood transfusions from pregnant women therapeutically. Hench, not satisfied with the results of these methods of treatment, decided to investigate the effect of hormones from the adrenal cortex which are also known to play a part in the endocrine control of pregnancy.

Now it so happened that working at the Mayo Foundation was E. C. Kendall, the eminent biochemist, who for some years has been interested in the chemistry of the adrenal cortex, from which he has isolated a number of hormones including, in 1935, "Compound E." Hench went to Kendall, therefore, and asked him if he could make available for clinical trial some of these adrenal cortical hormones in order that the possibility of their therapeutic effect in rheumatoid arthritis might be investigated. Kendall set to work and by means of a method of partial synthesis largely worked out by himself and further elaborated by Sarett of the Merck organisation, it was possible by September 1948 to produce a very small quantity of this precious material for a clinical trial on a small series of cases.

By the beginning of this year Hench and his colleagues[3] were able to announce that 14 cases had been treated with "Compound E" and that another two cases had been treated with the adrenocorticotrophic hormone (ACTH) of the anterior lobe of the pituitary. Improvement followed within a few days. Pain, stiffness, and limitation of movement were reduced; tenderness and muscular pain disappeared, appetite and weight were regained, toxicity gave place to euphoria, the blood sedimentation rate fell, and the anæmia was rectified.

Let me quote to you a description of the first case which was treated[4]:—

> "Compound 'E' was administered to a female patient aged 29, who had had severe rheumatoid arthritis for 4½ years. She had not responded satisfactorily to any method of treatment, and many joints were swollen, stiff, and very painful on movement. Radiographs disclosed severe destructive changes in the right hip and less severe lesions in other joints. The blood sedimentation rate was 108 mm. and the patient's condition appeared to be deteriorating. On September 20th 1948 she could hardly get out of bed, and on that day intramuscular injections of 'Compound E' were started in daily doses of 100 mg. No change was noted until September 30th, when she rolled over in bed for the first time with ease and reported much less muscular stiffness and pain. On the next morning all muscular stiffness had left her, her appetite returned, and she walked with only a slight limp. By the seventh day of treatment all tenderness and pain on movement were lost and even swellings were greatly lessened. The next day she went out shopping for three hours, returning tired but with no stiffness or pain."

And here is an account of one of the cases treated with ACTH:[5] —

> "A child of 11 suffering from rheumatoid arthritis was treated with ACTH in a hospital in Philadelphia. There was alleviation of all symptoms after three hours, and after eight hours al symptoms had disappeared. The child was running about and the E.S.R. was normal. The reversa of symptoms lasted eight days and then the disease returned."

Now these clinical trials, small though they were, were conducted with very considerable care and forethought. The history-taking, and all subsequent interviews were recorded on the new wire-recording system which is now rapidly replacing gramophone discs, so that any improvement in well-being could be immediately detected. Films were taken showing the range of joint movements and the gait before and after treatment.

Control injections of cholesterol were from time to time substituted for the active material and even the clinical investigators themselves did not know whether they were giving control injections or the active material.

This study was presented at the recent International Congress on Rheumatology in New York, and everyone there was completely convinced that the claims were genuine though they are at the moment extremely modest. Hench insists that this is not to be regarded as a method of treatment of rheumatoid arthritis at the moment, but merely as an interesting experimental observation.

These trials have been confirmed in four other centres in the United States—in New York, in the Massachusetts General Hospital by Walter Bauer, in Chicago by Wolfson, and in San Francisco—and all these workers, some of whom are extremely critical and sceptical rheumatologists, are quite convinced of the efficacy of the treatment. Walter Bauer at this Congress, for instance, said, " It works—this is no humbug—this is the real thing." Even *The Times* permitted itself the licence of quoting from the Congress someone who said, " This is the real McCoy." One of the patients after two days of treatment was described as having " literally danced a jig." So there is no doubt at all that this is a true bill. A very great discovery in clinical medicine has been made, a discovery probably as great as that of penicillin.

Possible Mode of Action of "Compound E"

How does it work ? Let me warn you that when we start talking about how it works we are in the position of the man who has just illuminated the dark room and is in the process of rearranging the furniture. Anything we say now is largely guesswork and may prove to be completely incorrect.

But there are two lines of thought which I should like to suggest to you as possibly having some sort of remote bearing on this problem. For some years now Selye of Montreal has been working on and writing about what he calls the " general adaptation syndrome."[6] His hypothesis is as follows : whereas there are certain specific adaptive reactions, for instance, serological reactions to specific antigens ; muscular hypertrophy following physical exercise ; and thickening of the skin over pressure points, there are also, he believes, a number of non-specific systemic reactions, mainly endocrine, which are designed to combat any damaging agent, and which result in a number of changes such as adrenal enlargement and involution of the thymus and lymphopænia. Selye regards this adaptation as occurring in three stages. The first stage is the " alarm reaction," and is the result of the sum of all non-specific systemic phenomena elicited on sudden exposure to stimuli to which the organism is not adapted, as, for instance, to cold or to injury. This alarm reaction proceeds in two stages, first the passive stage or what at the present moment we call " shock," with such symptoms as hypothermia, hypotension, increased capillary permeability, and so on ; and then a stage of defensive reactions or " counter-shock " in which enlargement of the adrenal cortex and increased output of ACTH and of cortical hormones occur.

The next is the stage of resistance, when an increased resistance is put up to the specific nociceptive agent with increased sensitivity to all other types of stress. Finally there is the stage of exhaustion where the condition of stress has been so prolonged that the defensive mechanism can no longer be maintained and therefore exhaustion and, in the experimental animal, death takes place.

Selye goes on to suggest that as a result of these non-specific systemic responses to various forms of stress there may arise certain " diseases of adaptation," the stage of resistance representing a condition of abnormal homeostasis of the body from which pathological disorders may develop. Thus the body in order to resist the effects of a particular injurious agent produces a series of pathological changes which may become permanent and which may over-correct for the particular stress. As the result of observations on experimental animals he suggests that hypertensive states, periarteritis nodosa, rheumatic diseases, nephrosclerosis, eclampsia, acute tonsillitis and Cushing's syndrome may represent " diseases of adaptation." For instance Cushing's syndrome may develop from continued excessive secretion of ACTH and adrenal cortical hormones, whereas Addison's disease and presumably rheumatic diseases could develop as the result of functional exhaustion of the adrenal cortex. By the way it is curious to note that rheumatic conditions are never found in association with Addison's disease.

A great deal of attention had been paid to this hypothesis long before Hench and Kendall's discovery was announced, and most physiologists and endocrinologists had already to a large extent accepted Selye's work.

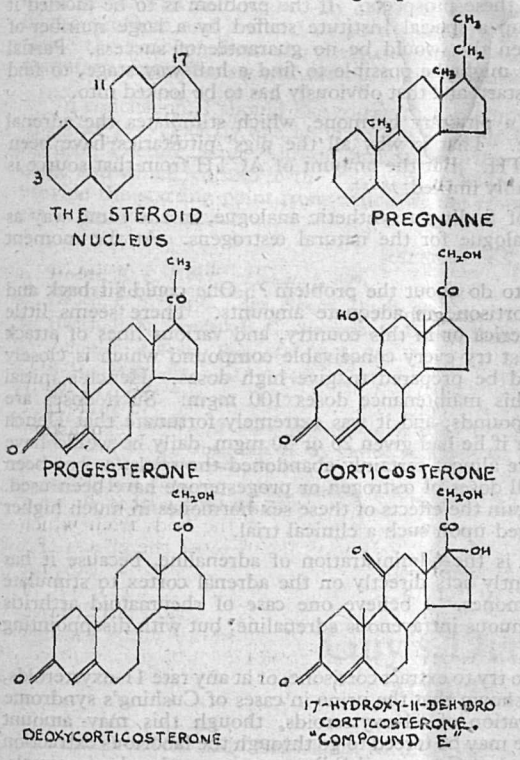
The second line of thought which I would like to suggest to you emerges from some recent work of Wolfson and his team in Chicago on gout[7]. They found that the 17-ketosteroid excretion in patients with gout is abnormally low and that this may be observed in the absence of any other manifestation of deficient androgen activity. They have put forward certain evidence to suggest that in gout abnormal androgens are developed which are not converted into 17-ketosteroids. Furthermore they have observed that the prodromal stage of an attack of gout is associated with a relative deficiency of 11-oxysteroid excretion in the urine and a spontaneous or induced increase of 11-oxysteroid production may lead to the rapid termination of an attack. Incidentally it has been shown already in one or two cases that compound " E " produces beneficial effects in the treatment of gout.

Expansion of the Therapeutic Field

I have thought it right to draw your attention to these observations of Selye and Wolfson, not because I think they explain the association between " Compound E " and rheumatoid arthritis, but rather because they suggest that this therapeutic field is going to expand. Already, for instance, three cases of acute rheumatic fever have been treated successfully with " Compound E."[8] Gout, as I have already mentioned, has been satisfactorily treated and it would seem likely that all those diseases which come under the rather vague heading of " collagen diseases "—that is, rheumatic fever, rheumatoid arthritis, ankylosing spondylitis, lupus erythematosus, scleroderma, and polyarteritis nodosa—may eventually prove to yield promising response to this kind of treatment.

Chemistry of " Compound E "

Let us now examine the chemical structure of " Compound E." If you look at the figure you will see first of all the arrangement of the steroid nucleus. The important carbon atoms at which substituent groups are found are C3, 11 and 17. Pregnane is the parent structure from which both progesterone and the corticosteroids are derived—progesterone and deoxycorticosterone are very closely related chemically. Corticosterone is a compound with a hydroxyl group at the 11-Carbon atom, and it will be seen that "Compound E" or 17-hydroxy-11-dehydrocorticosterone is also an " 11-oxysteroid," whereas *de*-oxycorticosterone has neither an oxygen (keto-) nor a hydroxyl group at the 11-Carbon atom. It is generally supposed, at the moment, that the functional properties of " Compound E," or " Cortisone " as it is beginning to be referred to, depend on a hydroxyl, or keto, group at the 11-Carbon atom, and on the hydroxyl-group at the C17 position. The substitution at the 11-Carbon atom is an extremely important point, for it is possible, though by no means easy, to synthesize compounds which have no substituent at C11. For instance, deoxycorticosterone acetate (DOCA) which is used in the treatment of Addison's disease is a synthetic compound. On the other hand the total synthesis of 11-oxygenated steroids has not yet been, or is likely in the near future to be, achieved, and all present supplies of cortisone depend on a partial synthesis starting from bile acids.



THE SUPPLY PROBLEM

This brings us to the supply problem. I have already indicated that the amount of "Compound E" available at the moment is extremely small. It took about five years for Kendall to produce enough of this precious material to allow Hench to conduct his very small clinical trial. Merck's are the firm of manufacturing chemists who have taken over the bulk production of this material and they have issued a warning that there will be no supplies before 1950, and only then will there be supplies for accredited teams of workers in this particular field. At the present moment Merck's are flying every week to the Mayo Clinic a week's supply of cortisone for 16 patients, and ACTH for five patients. The material costs £4,500 for a three weeks' course for one patient, and if the treatment is discontinued the patient relapses. I am told that it is impossible to buy a pig's pituitary anywhere in the world; it has all been "cornered" for the extraction of ACTH. I am told also that the world supply of bile acids is sufficient only to produce a mere drop in the therapeutic ocean. Therefore the supply situation is very serious indeed. It has been promised by Hench and by the Therapeutic Trials Committee of the Council of Pharmacy and Therapeutics of the American Medical Association that a small sample—and you can be certain that it will be a small sample—of material will be sent to this country for confirmatory trial by our group (Copeman, Savage, Dodds, Spencer Paterson and myself) and others when it is available, but we have very little hope indeed of seeing any of the material this side of Christmas.

THE FUTURE

That is the supply position. What of the future? First of all this work has raised a stupendous chemical problem. Is it going to be possible to produce cortisone by total synthesis? Sir Robert Robinson, who is regarded even by the Americans as being further ahead in this field of steroid chemistry than anyone else in the world, has expressed himself very gloomily indeed about these prospects. If the problem is to be tackled it will probably be necessary to set up a special Institute staffed by a large number of expert steroid chemists, though even this would be no guarantee of success. Partial synthesis is a little more likely. It might be possible to find a half-way stage, to find one of these steroids from which to start, and that obviously has to be looked into.

What about ACTH? ACTH is a pituitary hormone, which stimulates the adrenal cortex to produce its own cortisone. That is why all the pigs' pituitaries have been bought up, to be extracted for ACTH. But the amount of ACTH from that source is obviously going to be very considerably limited.

Then there is the possibility of finding a synthetic analogue, in the same way as stilbœstrol has proved to be an analogue for the natural œstrogens. At the moment such a possibility seems unlikely.

In the meantime what is there to do about the problem? One could sit back and wait until the chemists provide cortisone in adequate amounts. There seems little inclination to do this either in America or in this country, and various lines of attack present themselves. First, one must try every conceivable compound which is closely related chemically to cortisone, and be prepared to give high doses. Hench's initial doses were 300 mgm. daily, and his maintenance doses 100 mgm. Such doses are tremendously high for steroid compounds, and it was extremely fortunate that Hench chose to use such large amounts, for if he had given 25 or 50 mgm. daily he would have produced no effects, and would have almost certainly abandoned the trials, as has been done every time comparatively small doses of œstrogen or progesterone have been used. It is obviously necessary to study again the effects of these sex hormones in much higher doses. Our group is already engaged upon such a clinical trial.

Another possible line of attack is the administration of adrenaline, because it has been shown that adrenaline apparently acts directly on the adrenal cortex to stimulate it to put out adrenal cortical hormones. I believe one case of rheumatoid arthritis has already been treated with continuous intravenous adrenaline, but with disappointing results.

Another line of attack would be to try to extract cortisone, or at any rate 11-oxysteroids, from natural sources. It has been shown that the urine in cases of Cushing's syndrome contains a *relatively* high concentration of 11-oxysteroids, though this may amount to only a few micrograms daily. We may be forced to go through the laborious extraction of urine of that kind just to get enough "Compound E" to act as a test batch on animals, or possibly for testing other compounds against it before applying them to human cases. Again, after strenuous physical exercise a relatively high concentration of 11-oxysteroids

is excreted in the urine—about 2 micrograms in a 24-hour specimen—so that it may even be worth while collecting all the urine from army recruits after a route march and extracting it to obtain small quantities of 11-oxysteroids. Already the athletic team at Guy's has supplied me with samples after the Annual Sports. In post-operative cases or after accidents or burns the 11-oxysteroid content of the urine rises, and it might be possible to collect urine from cases of this kind.

Lastly, in the latter months of pregnancy relatively high concentrations of 11-oxysteroids are excreted in the urine, and it may be advisable to collect large quantities of urine from maternity wards for extraction.

In the course of the clinical trials there must of course be a careful study of the side-effects. So far certain side-effects have been noted, hypertension, hirsuitism, the development of the round, moon-shaped face suggestive of Cushing's syndrome, and amenorrhœa. It seems that such effects are more likely to occur after the administration of ACTH than after cortisone ; but if we are to embark upon heroic doses of such compounds as progesterone we shall have to keep our eyes open for all sorts of unpleasant side-effects, including those which we have not yet contemplated. For instance, if 20 mg. of progesterone are administered to a rat it becomes immediately anæsthetized with absolute muscular relaxation.

Thus, even though there are virtually no existing supplies of cortisone or ACTH, there is no doubt at all that it has been decided to tackle this problem on a really large scale and with great determination and earnestness. A Question has already been asked in Parliament as to what the Medical Research Council proposes to do about it, and I do not think that I am giving away any secrets in telling you that the Medical Research Council does propose to do something, probably in quite a big way. There are certain other influential and well-to-do charitable foundations which have become interested in the problem and are said to be prepared to put up considerable sums of money to tackle the problem from the chemical point of view. There are even certain firms of manufacturing chemists who are not altogether disinterested.

In conclusion, I should like to say that it seems to me singularly appropriate that in this year 1949, exactly one hundred years, as Sir Henry Dale reminded us in the Third Addison Lecture, after Addison first studied the condition of anæmia which bears his name and which led him to the discovery of Addison's disease, the adrenal glands should provide the starting point from which we are embarking on a new and equally exciting era in medical research.

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Guy's Diary

AUGUST

SOCIAL

15th. 3.30. The Lady Ebbisham, M.B.E., opens The Derry Roof Gardens (Derry & Toms Ltd.), High Street, Kensington, W.8, in aid of the Guy's Hospital Ladies' Association Comforts Fund, the gardens to remain open for the week.

Correspondence

Reports upon Games

SIR,—It is impossible to be indifferent to criticism, especially emanating from critics who could scarcely be more qualified to act in this capacity, being such avid and longstanding readers of the *Gazette* as Dr. Stewart Wacher and Dr. I. H. Busteed. Their letters prompt the captain and secretary of the Cricket Club to acknowledge that the reports of matches arising directly or indirectly from them have not all attained a standard to be desired, and to express regret that the considerable and discriminating appetites of these supporters for information have not been better satiated. While a dirth of numerical details may easily be remedied it is very difficult to find people able and willing to write good descriptive commentaries upon the matches. Certainly there are none outside the team itself since our train of active followers is non-existent. Incidentally, in fairness to the author, I would like to point out that the account of the first match against Bart.'s described by Dr. Wacher as "long and garbled" was considerably appreciated by a number of readers. Furthermore I strongly refute his suggestion that "publicity acts as propaganda to spur on individuals to be chosen to represent the Hospital." I am quite sure that the majority of our members will support me in saying we play cricket for the pure enjoyment of the game and not as a means to the glorification of our ego.

Remembering Dr. Busteed's enthusiastic support in the cup final four seasons ago I can well appreciate his annoyance at being unable to ascertain the dates of cup ties, but am impelled to say that under present circumstances it is nigh impossible to arrange any but the first round matches much beforehand. May I respectfully suggest that in these over-administrated days the calls upon students by various examining bodies and the Medical School Office are for more persistent and exacting than they were, say, thirty or forty years ago. To overcome this, so that the strongest teams may be fielded, the arrangements have to be made to be mutually agreeable to both sides. Then again, it becomes increasingly difficult when, as last year, two strongly matched sides meet and draw, necessitating, as in that instance, a total of five replays. In an effort to relieve this I propose to call the Annual General Meeting of the United Hospitals almost at once, instead of just before the season commences, so that the cup draw may be accomplished and the hospitals able to incorporate the preliminary rounds in their fixture lists.

For the future reporting of cricket matches it is proposed that a complete score card of all games shall be submitted as soon as possible so that the editor may utilise the information as he pleases and, on suitable occasions, we shall, if possible, provide a written commentary as well.

Yours, etc.,

P. S. B. RUSSELL,
Captain.

Guy's Hospital,
S.E.1.

"The Endocrines."

SIR,—Dr. Bishop complains about the misuse of the word "Endocrine." But English people are always misusing words. We borrow words from other languages. We misuse words in our own. That is how our language has grown. Look what Humpty-Dumpty has to say about it: "There's glory for you." "I don't know what you mean by 'glory'" Alice said. Humpty-Dumpty smiled contemptuously. "Of course you don't till I tell you. I meant 'There's a nice knock-down argument for you!'" "But 'glory' doesn't mean 'a nice knock-down argument,'" Alice objected. "When *I* use a word," Humpty-Dumpty said in rather a scornful tone, "it means just what I choose it to mean, neither more nor less." "The question is," said Alice "whether you *can* make words mean so many different things." "The question is," said Humpty-Dumpty, "which is to be Master—that's all." Alice was too puzzled to say anything, so after a minute Humpty-Dumpty began again. "They've a temper, some of them—particularly verbs, they're the proudest—adjectives you can do anything with, but not verbs—however, *I* can manage the whole lot of them! IMPENETRABILITY! That's what I say!" . . .

Yours, etc.,

PHILLIP ZORAB.

Blood Pressure

SIR,—Dr. Baker's lecture in the April *Gazette* gave a full and very interesting account of the diagnosis and prognosis, but did not touch upon the ætiology and essential treatment and prevention of the troubles he enumerates. No doubt the time for a lecture necessitates a limit, but one would think that a reference might well have been made to Alex Haig's two books.

It is strange how these books have been disregarded; written fifty-eight years ago they have gone through many editions, but one never sees them referred to by medical writers. Yet Haig conclusively demonstrates, by clinical and laboratory work, that high blood pressure and all its evils are caused by the excess of uric acid produced by a wrong diet. The capillaries are mechanically blocked by gelatinous uric acid that ought to have been a urate. An acid state of the blood caused by the meat diet and the salt we are so fond of, along with the excess uric acid formed directly by tea, cocoa, coffee and chocolate, gives rise not only to high blood pressure but indirectly to almost every sort of illness—either as its cause or its aggravation.

Treatment along these lines works wonders, as I can testify after some fifty years' experience. And it is undoubtedly a fact that the public health would be vastly improved by following Haig's rules of diet and by warm clothing. Of course it is obvious that under the fee for service system it is not in the interest of doctors to keep everyone well! Let us then vote for the capitation plan that makes it in our interest to keep folk alive and well.

Yours etc.,

Mangonui, N.Z. E. S. DUKES.

Reviews

A Psychiatrist Looks at Tuberculosis. By ERIC WITTKOWER. N.A.P.T. *Price* 12*s.* 6*d.*

This book is the outcome of an investigation lasting two-and-a-half years by a physician who is recognised to be the father of psychosomatic research in Great Britain. In that time Dr. Wittkower interviewed the formidable total of seven-hundred-and-eighty-five patients, each for at least two hours, and some for much longer. His findings are set out in three main sections: the behaviour of tuberculous patients and their reaction to illness, the factors determining this behaviour, and the relevance of emotional factors in the aetiology and course of the disease. Of these, the first two sections are the more satisfactory; the value of the third is reduced by the absence of controls. The research has been done with the scrupulous care which marks all Dr. Wittkower's work; this study is by a long way the most extensive in its field and will come to be acclaimed as the best.

D. O'N.

Anæsthetics for Medical Students. By GORDON OSTLERE. Churchill. *Price* 7*s.* 6*d.*

This should prove a useful little book for the anæsthetic clerk and the house officer. Nearly all the modern methods of administration are included with particular emphasis on the semi-cloud type of apparatus used with ether. Unfortunately the author considers that "open ether" is so rarely necessary that he omits the subject altogether. The book is concise, clear, easily assimilated, and essentially sane and practical. Though Dr. Ostlere's free and easy style in places may be irritating to some, yet it is arresting and forceful in stressing necessary points.

D.M.C.

Schafer's Essentials of Histology. By H. M. CARLETON and E. H. LEACH. 15th Edn. Longmans, Green & Co. *Price* 25*s.*

The 15th edition of this well-known textbook embodies some improvements over its predecessors. New features include further correlation of structure with function, and a clever method of labelling photographs, which could usefully be extended throughout the book. In many photographs, however, the detail is far from clear, and the text contains descriptions of detail not usually seen by medical students using ordinary technique. The book retains the character of a useful reference work.

P.L.

Sport

CRICKET.

Guy's *v.* Ditchling

July 26th, 1949.
at Ditchling. Result—Won.
Ditchling 217-7 dec. ; Guy's 219-5.

Ditchling chose to bat and suffered some bumps and bruises off the first few balls from Trist owing to some irregularities in the wicket. Two wickets fell for 39 runs, each time due to a mishit hook which finished up in Cahill's hands at forward short leg, both from the bowling of Trist.

None of the batsmen let any ball go by unheeded, and the score mounted steadily and rapidly. 150 came in 111 minutes and 200 in 143 minutes. A short boundary up the hill and a long one the other side by the brook helped the batsmen not a little, but they missed no opportunity to hit the ball. A very sporting declaration, giving Guy's only 5 minutes less batting time, was made when the seventh wicket fell.

Guy's started slowly—at least, they scored just a run a minute in the first 30 minutes. But Bisson Dath, going in after Harris was out with the score at 30, hooked a smart four and kept the score moving. He had just caught and passed Woodford's score of 26 when he was bowled. Two quick wickets followed, then Prentice joined Woodford with the score at 91. These two stayed together and the 100 went up in 92 minutes. The pace began to mount as Woodford lost his earlier caution and the next 50 came 17 minutes later. The possibility of getting the runs had seemed rather dim before, when 128 runs were needed in 47 minutes, but now things were brighter—69 in 21. Woodford and Prentice made the next 50 in 11 minutes dead. The last over was called and 7 were needed to win. Prentice blocked the first and mishit the second for one. Woodford was caught by the sightscreen off the third. Prentice collected another single off the next. Trist then got two and finished with a boundary.

Woodford had made 107 and Prentice 53 not out.

We have to thank Dr. Herbert Richards, who left Guy's some 40 years ago, for arranging the match and for his hospitality in providing for our lunch and tea.

Guy's *v.* Finchley

July 30th, 1949.
at H.O.P. Result—Lost.
Finchley 135 ; Guy's 89.
(Woodford 32 ; Jones 23 not. Bisson Dath 4—26 ; Smith 2—16.)

Guy's *v.* Mr. John Tanon's XI

July 31st, 1949.
at H.O.P. Result—Lost.
Guy's 48 ; Mr. J. Tanon's XI 49—3.
(Bisson Dath 2—17.)

Guy's *v.* Merstham

August 2nd, 1949.
at Merstham. Result—Lost.
Merstham 129 ; Guy's 59.
(Jones 19. W. H. Garland 5—37 ; Woodford 4—37.)

INTER-HOSPITAL CUP SEMI-FINAL

Guy's *v.* St. Mary's

August 3rd, 1949.
at Teddington. Result—Lost.

ST. MARY'S

A. Garnham c Platt, b Russell	0
J. I. S. Robertson c Bisson Dath b Graham	35
J. D. Somper b Gray	11
R. D. Morebey b Smith	2
J. H. Willis b Russell	103
A. R. Teuten c Platt b Graham	10
D. Kelleher b Russell	59
T. R. Beatson c Platt b Gray	6
S. Simmons b Russell	4
R. D. H. Reddy not out	2
D. J. Parry b Gray	1
Extras	11
	244

Bowling : P. B. S. Russell 19—1—40—4 ; K. W. Gray 18—5—38—3 ; E. W. Graham 12—0—63—2 ; T. Smith 6—0—15—1.

GUY'S

P. L. Pickett b Morebey	11
J. F. Woodford b Simmons	5
P. S. B. Russell c Robertson b Garnham	27
J. D. Williams b Morebey	82
K. W. Gray run out	8
A. M. Platt c Reddy b Garnham	14
A. F. Jones b Garnham	1
E. W. Graham b Garnham	0
H. R. Bisson Dath c Kelleher b Garnham	6
T. Smith not out	25
W. M. E. Tweed c Reddy b Garnham	0
	179

Bowling : A. Garnham 19—1—69—6 ; R. D. Morebey 19—8—43—2 ; S. Simmons 7—0—20—1.

It is regretted that there was no publication of the date of this match in the last *Gazette*, but the fixture was made only four days before the match was played.

RIFLE CLUB.

United Hospital's Challenge Cup.

Held at Bisley Camp on July 8th 1949.

Result.

1st.—Guy's	461
2nd.—St. Bart's	448
3rd.—St. Mary's	430

This year's cup match provided Guy's with its 2nd victory in the four years since the competition was resumed after the war in '46. The Cup was won previously in '46.

The weather made shooting very tricky this year, the wind blowing across the range being very variable, and the very hot sunny conditions produced a heat haze which at the longer distances added to the hazards of shooting.

At 200 yds. Guy's produced some very fine shooting, scoring 163 out of a possible 175. Despite this we came away with only a 5 pts. lead over St. Bart's (158/175). St. Mary's were in 3rd position with London and St. Thomas's following on. At 500 yds. the weather conditions began to have effect, the Guy's team having many anxious moments, eventually finishing with 150/175, having had their lead of 5 pts. now reduced to 2 pts. Bart's scoring 153/175.

At 600 yds. Guy's returned a score of 148/175, a mediocre score but, nevertheless, a useful one under such conditions, the sun having now moved round casting a shadow across the targets which, with the heat haze, made them look extremely indistinct. St. Bart's. could not even keep up with this moderate scoring and returned 137/175 giving Guy's a win by 13 pts.

Individual Scores.

	200 yds.	500 yds.	600 yds.	Total
A. P. Jennings	33	30	31	94
J. D. Morris	33	31	29	93
W. J. Cowper	32	31	30	93
D. J. Cliffe	33	30	29	92
C. P. B. Brook	32	28	29	89
				461

B. D. Lascelles of St. Bart's. was top individual scorer of the competition with a score of 98 out of a possible 105.

The Cup and Medals were presented to the Guy's team at the Bisley Prize meeting on July 16th by the High Commissioner for Canada.

SAILING

The sixth Inter-Hospital Race of the season was sailed at Burnham on Saturday, July 30th. The result was St. Thomas's 1st; Middlesex 2nd; Guy's 3rd; St. Mary's 4th. The London and Royal Dental Hospital boats retired.

The series of Inter-Hospital Races for the Bannister Cup finished last Saturday. St. Thomas's Hospital won the cup, with Guy's as runners-up, as last year.

Results :

1st—St. Thomas's	36 pts.
2nd—Guy's	31 pts.
3rd—London	30 pts.
4th—St. Mary's	26 pts.
5th—Middlesex	25 pts.
6th—U.C.H.	23 pts.
7th—Royal Dental	18 pts.
8th—Royal Free	14 pts.
9th—Bart's	4 pts.

LAWN TENNIS

Summary of Season 1949.

	1st VI	2nd VI
Played	13	9
Won	8	7
Lost	5	2
Cancelled	4	3

Inter-Hospital-Cup

2nd Round. Guy's beat University College Hospital 12—0

Semi-Final Westminster Hospital beat Guy's 8—7

Final. Westminster beat St. Thomas's Hospital

Lane-Washbourne Cup

Final. F. A. F. Biddle beat E. Searle.

Inter-Hospital Singles.

Final. D. Mackenzie (Westminster) beat F. A. F. Biddle (Guy's)

TO CONTRIBUTORS

The burden of the editors and compositors is lightened, accuracy is assured and publication facilitated when contributors :-

1. Submit copy, in typescript or legible writing on *one* side of the paper only.
2. Take particular care over proper names and initials.
3. Keep covering letters separate from copy.
4. Arrange for copy to be deposited at the *Gazette* office as early as possible and, in any case, not later than first post on the Monday of the week of publication.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL, S.E.1

Applications are invited for the post of **Trainee Registrar to the Diagnostic X-ray Department** from those who have held the appointment of Medical or Surgical Registrar. Applicants must hold a higher medical or surgical qualification, and will be expected to take the course of the Dilpoma of Medical Radiology. The appointment will be for two years from 1st October, 1949. Forms of application are obtainable from the Medical School Office and should be forwarded to the Dean not later than 26th August, 1949. Salary at the rate of £650 per annum.

Applications are invited for the appointment of **Assistant Clinical Pathologist** for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be forwarded with the names of three referees not later than 23rd August, 1949.

Applications are invited for the appointment of **Registrar** (part-time) in the **Ophthalmological Department** with attendance on two sessions per week, for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be forwarded with the names of three referees, not later than 23rd August, 1949.

Applications are invited for the appointment of **Registrar (Whole-time) to the Neurological Department** for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be forwarded to him not later than 29th August, 1949.

Applications are invited for the appointment of **Senior Registrar to the Ear, Nose and Throat Department** for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School and should be forwarded to him not later than 31st August, 1949.

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited for the post of Half-time **Assistant in the Department of Preventive Dentistry** to commence duties on 1st October, 1949. Minimum salary £500 per annum plus superannuation and family allowance. Forms of application are obtainable from the Dean, Guy's Hospital Dental School, London, S.E.1, to whom applications with the names of three referees should be sent not later than 1st September, 1949.

PAPERS BY GUY'S MEN

Allott, Frank. The Problem of Child Management in Dental Practice. *Dent. Rec.*, 1949, **69**, 150.

Crisp, E. J. Manipulation of the Spine. (Discussion). *Proc. Roy. Soc. Med.*, 1949, **42**, 417 (Sect. Phys. Med.).

Foxon, G. E. H. Biology in the Medical Curriculum. *Nature*, 1949, **164**, 157.

Harkness, A. H. Some aspects of the Non-Gonococcal Infections of the Genital Tract. (Abridged). *Proc. Roy. Soc. Med.*, 1949, **42**, 390. (Sect. Obst. and Gyn.).

Kauntze, Ralph. Gout. *Clin. J.*, 1949, **78**, 132.

McEvedy, Peter G. Symptoms following operation for Peptic Ulcer. *Clin. J.*, 1949, **78**, 125.

ROYAL COLLEGE OF PHYSICIANS OF LONDON

The next EXAMINATION for the MEMBERSHIP will commence on *Monday, 26th September*, 1949.

Prospective candidates are asked to note that entries accompanied by the certificates and testimonials required by the Bye-Laws must reach the College not later than first post on *Monday, 29th August*, 1949.

Candidates who propose to submit Published Work under the regulations are required to give twenty-eight days' notice and should apply in writing to the Registrar, without delay, for detailed instructions as to the procedure they should follow. The last day for receiving completed entries for Published Work is also *Monday, 29th August*, 1949.

M.R.C.P. EXAMINATION

Alteration in the Regulations

To take effect immediately :

1. No candidate shall be admitted to the Examination until he has been qualified for eighteen months.
2. Candidates may be asked to give details of the appointments they have held and to nominate a referee who, on request, could give information as to the work these appointments have involved.

To take effect from January, 1950 :

1. No candidate will be admitted to the Examination more than twice in twelve months.

CHANGES OF ADDRESS

D. H. Broughton, M.B., B.S., Flat 3, Stamford Lodge, Hayling Island, Hants.

H. A. Buck, M.R.C.S., L.D.S., 4, Stainsby Drive, Mansfield, Notts.

R. W. Doy, M.R.C.S., L.R.C.P., 77, Priors Wood Road, Taunton, Somerset.

C. H. Kinder, M.B., B.Ch., 34, Redfield Lane, S.W.5. (Tel. FRObisher 6817.)

BIRTHS

DOY.—To Joan, wife of R. W. Doy, at Musgrove Park Hospital, Taunton—a daughter (Marion), sister to Maureen and Michael.

GRUMMITT.—On July 28th, 1949 at Guy's Hospital, to Olive (née Chase), wife of P. C. Grummitt, B.D.S.—a second son (Frank Michael).

WILLIAMSON.—On July 6th, 1949, at Harpenden Memorial Hospital, to Margaret (née Morrison), wife of John R. Williamson—a second son (James Stephen).

MARRIAGES

BAILEY—GREATOREX.—On July 16th, 1949, at St. Mary's, Radcliffe-on-Trent, Anthony Alan Bailey, L.D.S., R.C.S. (Eng.), son of Mr. F. C. Bailey and the late Mrs. Bailey, of Hatch End, Middlesex, to Joan Greatorex, S.R.N., R.S.C.N., eldest daughter of Mr. and Mrs. G. M. Greatorex, of Radcliffe-on-Trent.

EVANS—MITCHELL.—On Sunday, 31st July, 1949, quietly, at the Church of the Ascension, Blackheath, Dr. Carlton John Evans, of Lewisham to Dr. Alexa Mitchell, of New Cross.

TAYLOR—HORNER.—On July 23rd, 1949, at St. Dunstan's, Mayfield, Gerald Strickland Taylor, B.A., to Norah Mary Horner, S.R.N.

DEATH

SALTMARSH.—On July 27th, 1949, at The Haven, Writtle, nr. Chelmsford, Walter Reuben Saltmarsh, aged 78 years. Clerk of Works, Guy's Hospital for 30 years (1901/31).

EDS. { H.A.R. / R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol LXIII. No. 1594 27*th August* 1949 *Ninepence*

PASSIM

IN this issue of the *Gazette*, we publish the fixtures for the coming season of the Hospital Rugby Football 1st XV., together with the draw for the Inter-hospital Rugby Football Cup and the dates on which these matches are to be played. Last year our side came as near to winning this latter competition as makes very little difference, and we would like to join with all our readers in wishing the new captain, "the fiery headed" Gwyn Davies, and his side, the very best of good fortune in the coming season. May their efforts not only be crowned with success, but may they play that quality of football which is both pleasing to play against and pleasing to watch, and which in the past has given both the side, and the hospital whence it was chosen, a name which was known and respected throughout the world of sport.

Whatever the outcome of the Walker Cup match this year, and whatever the results in the Olympic Games last year, this country's position in the field of games and sport is in many ways unique. Whereas we have had our fair share of world-beaters, our distinction has surely been that we are a nation of all-rounders, who play their games for recreation and amusement, amateurs in outlook and in the finest sense of the word. In that tradition the result has been held to be of secondary importance to the game, the man to be but part of his team, the referee or umpire to be a friend of both sides, mutually employed, as a host to direct the entertainment. Such was British sport before it became a business. If a man on one side was hurt it was a matter for mutual grief, that the combat should no longer be fair. If an infringement of the rules occurred it could with certainty be assumed that it was an accident, and although mistakes were forgiven, it was not expected to happen too often. Worse than playing against a bad sportsman was to number one amongst one's own side. Sharp practice surely had no place in the recreative pastimes of an Englishman's leisure hours.

But with the advent of the popular press, and worse still since the number in the stands have come so grossly to exceed the number on the field, the very words "recreation" and "sport" have lost the quality of their meaning. To see men of opposite sides fighting as in a tavern brawl is no longer a disgraceful, rare occurrence, while to dodge the eyes of the referee and appeal against his decisions with arms held high and disgruntled mien, should he be found out, has become an integral part of a footballer's armamentarium. And the onlookers, far from showing distaste, encourage and display amusement at one form of behaviour, while endorsing both manually and vocally, the other. To come from school rugger, where sportsmanship and fair play are synonymous with honour, to the club game has been a discouraging shock to many a young enthusiast in recent years.

The core of the matter is one of morality, and there is perhaps no reason to wonder that when morals as a commodity are losing value in political, business and every other sphere, there should be a similar deterioration in recreational and sporting life. Except a priest, no man requires a higher moral code than a doctor. For this reason alone let Guy's this year set an example of single-minded sportsmanship, to say nothing of respecting the memory of William Webb Ellis "who," in 1823, "with a *fine* disregard for the rules of football, as played in his time, first took the ball in his hands and ran with it, thus originating . . . . the Rugby game." He was only a school boy, he played his prank openly, and later had it incorporated in the rules. If "dirt" in the scrum and outside it is reckoned an improvement in the game we have inherited from that young man, let it likewise be incorporated. Until it is, let Guy's set an example of playing not only to the rules, but in the spirit of the game, which is long overdue.

Malignant Disease of the Mouth

By S. H. WASS, M.S., F.R.C.S.

A Clinical Lecture delivered in the Medical School on Thursday, May 12th, 1949.

GENTLEMEN,—I have chosen the subject of malignant disease of the mouth for several reasons. In the first place, apart from growths of the tongue and lip, little is known about malignant disease in other situations in the mouth. As a result of errors in diagnosis of malignant disease in the well-known sites and ignorance of its occurrence in others, we have to deal only too often with patients in whom the disease has been unrecognised for many months. The seriousness of this group of diseases is another reason for bringing it to your attention. The prognosis of malignant disease of the mouth is extremely grave and can only be improved by constant efforts at early diagnosis.

I shall first give you a composite picture of malignant disease of the mouth, dealing with the clinical and pathological features and the principles of treatment from a general point of view. In conclusion I shall try to summarise the main features of the disease at different sites in the mouth and mention the specific treatment and prognosis of each.

The Site of the Primary Growth.

The commonest site for malignant disease of the mouth is the tongue. The second commonest is the lip. It next occurs, in order of frequency, in the palate, the tonsil, the floor of the mouth, the internal aspect of the cheek and the alveolar mucous membrane. To give an idea of the relative frequency in these sites, malignant disease in the tongue is three times as common as in the lip and six times as common as that occurring anywhere else in the mouth. Nevertheless, the rarer sites I have mentioned, the palate, the tonsil, the floor of the mouth, the inner aspect of the cheek and the alveolar mucosa, together comprise about 30 per cent. of all cases of malignant disease of the mouth. It is therefore important to know of its occurrence in these situations and to be able to recognise it.

From the primary site malignant disease can spread to involve adjacent structures and in late cases it may be difficult to know where the growth first began. For example, it can spread from the soft palate to the pillars of the fauces, from the floor of the mouth to the tongue and *vice versa*, and from any situation the growth can spread to involve the bone of the lower or upper jaw. Primary growths in the mouth, like all malignant diseases, will sooner or later give rise to metastases in the regional lymph glands. It is in those cases where the disease has spread to involve adjacent structures, particularly the bone, and has finally produced metastases in the lymph glands of the neck, that the prognosis becomes so extremely grave. If treatment is begun before there is spread to a large area in the mouth, before there is secondary bone involvement and before there is metastasis to the neck, the prognosis is materially improved.

Pathological Features.

There are three main pathological types of malignant disease of the mouth. The commonest is the *malignant ulcer* with its classical raised, rolled and everted edge. Next common is the *papilliferous type of growth*, the fronds of which may be delicate or coarse. The third and least common is the *nodular or infiltrating variety*, where the growth presents as a nodule spreading in the sub-mucous plane, or infiltrating deeply to involve adjacent structures, and only ulcerating late in the course of the disease.

The histological features of malignant growths of the mouth are varied and it must be remembered that both epithelial and mesothelial tumours may occur. The epithelial tumours, the carcinomata, are much commoner than the mesothelial sarcomata. The commonest epithelial tumour at any site in the buccal cavity is the *squamous-celled carcinoma*. This type of growth may show all degrees of differentiation or be grossly anaplastic and, as you are aware, the greater the degree of anaplasia the worse the prognosis. In certain situations in the mouth there occurs another variety of epithelial tumour known as the *lympho-epithelioma*. This tumour contains undifferentiated epithelial cells and, both within the tumour mass and the metastases, lymphoid cells are also found. This tumour is not common but occurs in the nasopharynx, the tonsil and occasionally in the posterior third of the tongue. Lymphoid tissue is normally present in these situations and may itself give rise to malignant tumours belonging to the lymphosarcoma group but nevertheless it is generally believed that the lympho-epithelioma is an anaplastic type of *epithelial* tumour. It often occurs at an earlier

age than other malignant growths of the mouth, quite half the cases being found in the 20–40 age group. The rarest histological type of carcinoma in the mouth is the *adeno-carcinoma*. This type arises from mucous glands and is therefore found in the floor of the mouth, the internal aspect of the cheek and the palate.

Whilst dealing with epithelial growths in the mouth I must mention, for the sake of completion, the *mixed salivary tumour*. Apart from the salivary glands the commonest site for this tumour is the buccal cavity, where it occurs notably in the palate and occasionally in the floor of the mouth, the inner aspect of the cheek or the alveolar margin. In these situations the histology of the tumour is the same as in the salivary glands. There may be some attempt at glandular formation or the epithelial cells may be present in solid sheets ; mucinous degeneration is often seen. Unlike a true carcinoma, the mixed salivary tumour is encapsulated, though tumour cells often invade the capsule. If the tumour and its capsule are not removed completely, or if the tumour is ruptured during removal with implantation of cells in the operation field, local recurrence will take place. The mixed salivary tumour is therefore locally malignant but does not give rise to glandular metastases. Pathologically and histologically it is similar to a rodent ulcer or basal-celled carcinoma. The clinical features of this tumour are quite different from those of other malignant growths in the mouth and will be discussed later.

The mesothelial tumours, the *sarcomas*, occur very rarely in the mouth except in the tonsil. Tonsilar sarcomas may be composed of small round cells like lymphocytes or larger round cells which are the reticulum cells of the lymphoid tissue. These varieties are known as *lympho-sarcoma* and *reticulum-celled* sarcoma respectively. Similar tumours occasionally occur in the base of the tongue, but elsewhere in the mouth round-celled and spindle-celled sarcomas are pathological rarities. When a sarcoma occurs in the tonsil or base of the tongue it presents as an ulcer or nodular lesion which may be softer than the corresponding variety of carcinoma. You must beware of that soft type of lesion and not dismiss the diagnosis of malignant disease because the tumour on palpation is not as hard as you would expect.

Clinical Features.

In discussing the clinical features of malignant disease in the mouth I shall speak chiefly of the carcinomas, because they are the common tumours you will meet. I have already mentioned one minor difference between the carcinoma and the sarcoma, namely the absence of hardness in the sarcoma, but otherwise the two lesions are essentially the same, alike in regard to symptoms, diagnosis, treatment and prognosis.

Malignant disease of the mouth occurs more commonly in men than women and carcinoma of the lip is practically unknown in women. The maximum incidence of malignant disease of the mouth is between the ages of 50 and 70 but no age is exempt. I have already warned you that the lympho-epithelioma occurs in younger people and because your patient has not reached the age of 50 you must not dismiss the possibility of malignant disease.

The *symptoms* can be divided into early symptoms, which you should aim to recognise, and late symptoms, which are in truth the premonitory signs of death. The earliest symptom is usually the tumour itself. The patient will notice a swelling or ulcer, or will feel something rough and pricking in his mouth like a foreign body. Unfortunately the early lesions are not painful. The patient will complain only of discomfort, which may be accentuated on eating or drinking hot fluids. Pain will come later, particularly with an ulcerating growth, and may be local or referred. Referred pain takes place through the medium of the lingual nerve and is classically radiated through the auriculo-temporal nerve to the ear on the side of the lesion. When the growth involves the floor of the mouth movements of the tongue are impaired and this may lead in the early stages to some slight alteration in the quality of the speech. In the region of the base of the tongue, the fauces and the tonsil, discomfort will again occur before pain, but other symptoms may be present. There may be slight difficulty in swallowing or a feeling as if the throat must be repeatedly cleared. Another important symptom, and one you must never neglect, is the occurrence of unilateral sore throat. The common sore throat is always bilateral and the only lesion besides malignant disease which gives rise to a unilateral sore throat is a quinsy.

The *late symptoms* of malignant disease are excessive salivation, fœtor and hæmorrhage. Excessive salivation is due to saliva dribbling from the mouth because mobility of the tongue is restricted and the patient is unable to swallow his saliva. Fœtor of the breath

is associated with infection secondary to the growth. Hæmorrhage may be marked by the production of blood-stained saliva or, in the latest stages, by profuse bleeding from the mouth.

The *physical signs* of malignant disease in the mouth fall into three groups ; first, the condition of the whole buccal cavity ; second, the characters of the growth itself ; and third, the state of the lymphatic glands in the neck. Gross oral sepsis is commonly associated with malignant disease of the mouth. The patient usually has filthy teeth jagged stumps, gingivitis and pyorrhœa. In a large number of cases there is evidence of leukoplakia in the tongue or buccal mucous membrane. These changes are associated with chronic irritation and commonly with a positive Wassermann reaction, but remember that a positive Wassermann does not exclude malignant disease.

The physical signs in the tumour itself are those of the classical malignant ulcer, the papilliferous growth or the nodular submucous lesion. The tumour is usually hard or firm on palpation, but sometimes soft. In late cases fixity to surrounding structures is present and when the growth affects the tongue or floor of the mouth ankyloglossia may be demonstrated. When the tumour occurs on the palate it is important to remember that it may be arising primarily in the maxillary antrum, the growth having ulcerated through the floor of the antrum to present as an apparent primary lesion of the palate. In such cases a clinical and radiological examination of the antrum must always be made.

The earliest and apparently most trivial lesion in the mouth can produce glandular metastases. When there is no palpable enlargement of the lymph glands of the neck it is a relatively good prognostic sign, but even after complete eradication of the primary growth the patient may still develop glandular metastases which will cause his death. In many cases enlarged glands are palpable when the patient is first examined. The glands may be firm or hard, discrete and capable of removal ; or they may be fixed to surrounding structures. Fixity and vagueness of definition of the edges of the glandular mass may be due to secondary infection and peri-adenitis. In such cases the fixity will disappear after adequate treatment of the primary growth and the enlarged glands will become more clearly defined. In other cases, however, the fixity is due to malignant invasion of surrounding tissues ; the glandular mass is then stony hard and clearly inoperable. It must be remembered that with malignant disease of the mouth glandular enlargement in the neck is not confined to the side on which the primary lesion is found ; lymphatic drainage across the mid-line is responsible for the occurrence of bilateral metastases. You must therefore examine both sides of the neck in every patient.

Differential Diagnosis.

In the differential diagnosis you will have to distinguish between malignant disease, syphilis, tuberculosis, dental or traumatic ulcers and simple neoplasms of the papillomatous variety.

In *secondary syphilis* the lesions in the mouth are multiple and other secondary manifestations are present, so the diagnosis is usually fairly simple. Syphilis presents itself as a localised lesion in the mouth in the primary and tertiary stages. A *primary chancre* occurs most commonly on the lip. The upper lip is the common site in either sex, whereas malignant disease is confined to the lower lip in men. A chancre occasionally occurs in other situations in the mouth. It appears as an indurated nodule associated with the development of soft glandular enlargement at an early stage, usually a few days after the appearance of the primary lesion. The diagnosis is confirmed by the demonstration of spirochætes in the exudate from the surface of the chancre. In *tertiary syphilis* the lesion is a *gumma*, presenting either as a firm nodule or an ulcer. A gummatous ulcer can be distinguished from a malignant ulcer by the fact that its edges are not raised, its floor is occupied by a washleather slough and there is no surrounding induration. With a tertiary lesion the Wassermann reaction is usually positive but because of the frequency of malignant changes in leukoplakia of the tongue a *positive Wassermann does not exclude malignant disease.* The only safe test is the administration of potassium iodide and if this does not produce resolution within two weeks a biopsy must be performed.

Tuberculous ulceration occurs in the tongue, lip or any part of the buccal cavity. The ulcers are often multiple, unlike the single lesion of malignant disease. Furthermore, tuberculous ulcers are painful and tender and often have undermined edges. An important diagnostic criterion is that tuberculosis of the buccal cavity seldom occurs except in association with laryngeal or pulmonary tuberculosis, or with lupus of the face.

A *dental or traumatic ulcer* arises from abrasions or continued irritation by broken teeth or ill-fitting dentures. It occurs on the edge of the tongue, inside the cheek or in the buccal sulcus and is usually painful. The edges of the ulcer are not raised but if secondary infection has caused surrounding induration it is impossible to distinguish it from a carcinoma. When an ulcer is due to local trauma removal of the offending cause will be followed by rapid healing. If the patient is forbidden to wear the denture or if broken teeth are extracted, the ulcer should heal in two weeks ; if it does not it is not a simple ulcer. This is a similar diagnostic test to the exhibition of potassium iodide in a suspected gumma ; if the lesion has no disappeared a biopsy must be performed in both cases without further delay.

It is impossible to distinguish between a *simple papilloma* and an early papillary carcinoma. If there is induration at the base of the lesion it is clearly malignant, but papillomata which are apparently innocent should always be removed and submitted to microscopical examination, for this is the only certain method of diagnosis.

The *mixed salivary tumour,* which I have already told you occurs in the palate and occasionally elsewhere in the mouth, is quite unlike any of the foregoing lesions. It is a rounded, circumscribed, mobile tumour without any surface ulceration. It feels firm or soft and is often mistaken for a *mucous cyst ;* the characteristic bluish colour of the cyst, however, is absent with a solid tumour. The mixed salivary tumour should always be excised and pathological examination will confirm the diagnosis.

Principles of Treatment.

The principles of treatment of malignant disease of the mouth demand that attention be paid to three things—the associated oral spesis, the primary growth and the glands of the neck, in that order. In all cases we must ask our dental colleagues to help us to get rid of oral sepsis before starting treatment of the primary lesion. They will scale good teeth, remove bad teeth and offending stumps and advise on the treatment of infection in the mouth and gums. Our aim should be to complete this phase of the treatment within one week.

Before radium was known surgery was the only method of treatment for the *primary lesion.* In many cases surgery was grossly mutilating and carried a high operative mortality ; the results, both in regard to local and glandular recurrence, often left very much to be desired. With the advent of radium and the advances which have taken place in radiation therapy we have been provided with new weapons of attack. The modern treatment of malignant disease of the mouth, so far as the primary growth is concerned, is largely a matter for the radiotherapist, though there are still definite indications for surgical excision and many occasions on which surgery and radiotherapy can be used in combination. There is probably no other field of cancer treatment in which this combination can produce such good results. In most cases, however, the primary growth is treated by radiotherapy alone and the cosmetic results are better than those following radical surgery. The operative mortality is also reduced and the five-year cure-rate is raised.

The three methods most commonly used for treating the primary growth are :—

1. Interstitial radiation by means of radium needles or occasionally radon seeds.
2. Surface application of radium needles on a suitable intraoral applicator.
3. Distant radiation therapy with deep X-rays or teleradium (radium bomb).

Interstitial radiation and surface application of radium needles on an applicator may be used when the growth is in an accessible part of the mouth. If the lesion is in an inaccessible situation distant radiation is more suitable. With growths near bone it is preferable to use surface or distant radiation because these methods carry less risk of bone necrosis. Whatever method of radiotherapy is used the total dosage will be of the order of 5,000 to 10,000 Röntgen units. If radium needles are used this is roughly equivalent to 10–25 milligrammes of radium left in position from five to seven days.

Surgical excision of the primary growth is indicated :—

1. When the lesion is directly invading bone ; radiotherapy is useless in such cases.
2. When gross infection and œdema cannot be cleared up with simple treatment.
3. When recurrence takes place after initial radiotherapy.
4. When the growth is shown to be radio-resistant and does not clear up completely with radiotherapy.

In all cases in which surgery is employed the growth must be widely excised, using the diathermy knife and not the scalpel.

In some cases the primary growth is treated by a *combination of surgery and radiotherapy*. When surgical excision is performed because the lesion involves bone a post-operative course of distant radiation is always given. When a small or doubtful lesion is excised and proved to be malignant the surgical treatment is supplemented by surface application of radium or by burying needles in the operation field.

The treatment of the *glands in the neck* presents many difficult problems. When the primary growth is treated with X-rays or teleradium the glands of the neck can be irradiated at the same time if thought desirable. In other cases it is usual to await complete healing of the primary lesion before embarking on treatment of the glands; the time required for such healing to take place is commonly 4–6 weeks. The condition of the glandular field may be :—

1. No palpable glands are present.
2. The glands are palpable, but mobile and operable.
3. The glands are fixed and inoperable.

When no palpable glands are present the problem of treatment is the most difficult of all, because we do not know if there is microscopical disease in the glands or not. We can decide to watch the patient and be prepared to undertake active treatment if glandular enlargement becomes evident later; we can give "prophylactic" radiation therapy to the glandular field; or we can perform block dissection of the neck to remove the lymph glands and any malignant cells they may contain. Commonsense dictates that if the patient is very old and has only two or three years expectation of life it is proper to adopt an expectant attitude. Such a course is also proper in patients who are bad operative risks—the frail subject with chronic bronchitis and emphysema and the fat patient with a short bull-neck. It must be realised that block dissection of the neck has an operative mortality of at least 10 per cent. in such patients. It is also justifiable to adopt the same conservative policy when the primary growth is at a site least likely to produce glandular metastases; examples of such sites are the lip and internal aspect of the cheek. "Prophylactic" radiation is criticised because, in spite of a full course of treatment, glandular enlargement may still develop at a later date; the limit of skin tolerance may then have been reached and further radiotherapy cannot be given. It is therefore said that block dissection should be performed in all but old and unfit patients even when no glands are palpable. Personally I cannot accept that view because I believe the operation, even in a fit patient, is one of considerable risk; and in many cases it may have been performed unnnecessarily. I prefer to give prophylactic radiation to fit patients who have no palpable glands if the primary growth is at a site likely to produce metastases. Block dissection may be performed later if the necessity arises.

If the glands are palpable, mobile and operable, the choice of treatment is between surgery and radiotherapy. Radiotherapy is indicated for anaplastic growths and sarcomas because surgery will not improve the prognosis in such cases. Radiotherapy must also be used for patients who are hopeless operative risks. Surgery is employed when the primary growth is of a more differentiated type and the patient is a reasonable operative risk. In these patients the operation of block dissection of the neck is usually combined with pre-operative X-radiation. *When the glands are fixed and inoperable* surgery must never be employed; palliative radiotherapy may occasionally prolong life.

Prognosis.

The prognosis of malignant disease of the mouth depends mainly upon early diagnosis. In many cases the patient dies from glandular metastases in spite of adequate treatment of the primary lesion, and if enlarged glands are present when the patient is first seen the prognosis is extremely grave. When the primary growth is a sarcoma or anaplastic carcinoma the outlook is almost hopeless. Growths in some situations in the mouth carry a worse prognosis than others; the outlook is best if the primary lesion is on the lip or inside the cheek, and worst if it is on the tongue, tonsil or soft palate. Carcinoma of the soft palate has the worst prognosis of all and is almost equivalent to a death warrant.

The five-year cure-rates for malignant disease of the mouth make gloomy reading and can only be improved by early diagnosis and effective radical treatment. Growths of the lip show about 50 per cent. five-year survivors; inside the cheek 60 per cent.; in the floor of the mouth 40 per cent.; and in the hard palate 50 per cent. These are the best figures. With carcinoma of the tongue the five-year cure-rate is only 22 per cent.; in the alveolus 16 per cent.; in the tonsil 24 per cent; and in the soft palate 5 per cent.

In the table which concludes this lecture I have attempted to summarise the main features of the different types of malignant disease of the mouth and to illustrate the application of the principles of treatment to individual lesions.

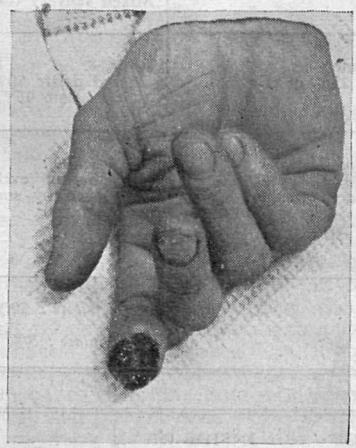
	TONGUE	LIP	PALATE
Clinical Features ..	Ulcer Papilliferous Infiltrating Any part of tongue. Fixation in late cases.	Ulcer Papilliferous Nodular Lower lip in men.	Ulcer Papilliferous Mixed salivary Hard or soft palate and pillars of fauces. (*N.B.*—Maxillary antrum).
Histology ..	Squamous-celled (Lympho-epithelioma).	Squamous celled.	Squamous celled. Mixed salivary tumour.
Glandular Enlargement.	Early 80% of all cases.	Late 25% of all cases.	Early Hard palate 50% Soft palate 95%
Treatment of choice for primary lesion.	*Anterior :* Radium needles. *Posterior:* Teleradium.	*Small lesion :* Excision or radium. *Large lesion :* Surface radium or needles.	*Hard palate :* Diathermy excision followed by surface radium. *Soft palate :* Teleradium.
5-Year Survivals.	22%	50%	*Hard palate :* 50% *Soft palate :* 5%

	TONSIL	FLOOR OF MOUTH	INSIDE OF CHEEK	ALVEOLUS
Clinical Features.	Ulcer Nodular	Ulcer Papilliferous Infiltrating Possible involvement of bone.	Ulcer Papilliferous Nodular Molar region.	Ulcer Papilliferous Infiltrating Molar region of lower jaw. Bone involvement common.
Histology ..	Squamous-celled Lymphosarcoma. Lympho-epithelioma	Squamous celled. (Adenocarcinoma).	Squamous celled. (Adenocarcinoma).	Squamous celled.
Glandular Enlargement.	Early. Carcinoma 66% Sarcoma 80%	Early. 80% of all cases.	Late. 50% of cases.	Early. 50% of cases.
Treatment of choice for primary lesion.	Teleradium.	Radium needles. Teleradium if extensive. Excision and X-rays if bone involvement.	Excision and radium if small. Teleradium if large.	*Early cases :* Surface radium or teleradium. *Bone involvement :* Excision and X-rays.
5-Year Survivals	24%	40%	60%	16%

Composite Ear Grafts in the Repair of Traumatic Amputations of the Finger Tips

by PATRICK CLARKSON.

THIS note is a short report on the use of a special type of graft for a common injury of the hand. During the last year we have had four occasions to use composite grafts of the ear lobule for out patients in the Accident Theatre. These grafts have been used for the repair of traumatic amputations of the tip of the digit, involving bone and nail, within 12 hours of the injury.



The ideal repair for these amputations is one which gives a stable painless restoration of length and form, and results in return of full sensation. This ideal is seldom attained for amputations of the finger which involve bone. The simplest repair is to cover the stump with a split skin free graft. The "take" of free skin grafts on bone is uncertain, and the stump so formed is likely to be adherent and instable; but if a local flap of finger tissue can first be brought across the bony stump the end result can be a very good functional digit, although sometimes it is one of poor appearance. Distant pedicle flaps, (cross-arm or thoraco-digital), can restore the pulp form in part or full; but return sensation in these flap repairs is generally poor. This is a particularly important disability in index and thumb injuries. For traumatic amputations of index and thumb thenar or palmar flaps must therefore be considered, as the skin of these flaps has a good supply of touch corpuscles. Proximal amputation or disarticulation are rarely indicated for injuries of digits; but they may have to be done when there are (in association with the amputation) extensive proximal injuries to the digit.

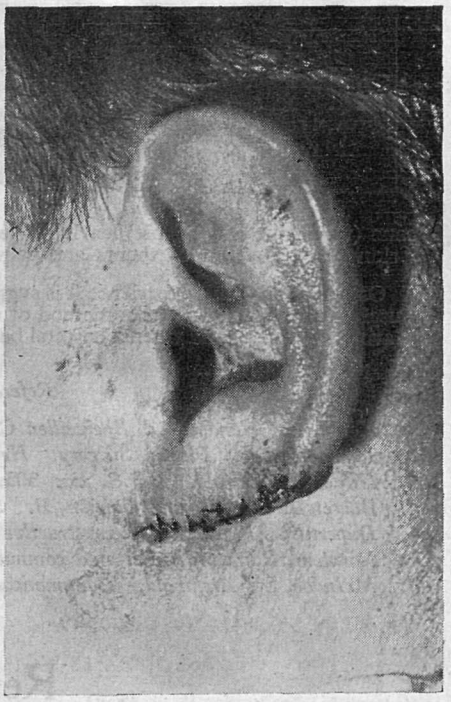
History of Composite Ear Grafts.

Free skin grafts are nourished directly by diffusion of tissue fluids during the first 24-72 hours, before the ingrowth of capillary loops. The take of free skin grafts from most donor sites is, on this account, prejudiced by the presence of fat on the deep surface of the dermis. For this reason it is customary to clear off all fat before a free graft is sutured into the recipient area. But Konig in 1912 (quoted by Staige Davis (2) in 1919) described how free grafts of the whole ear margin could be sewn into nostril defects and would take. The success of these composite thick grafts is possibly due to the early establishment of end-on anestomoses between capillary loops from the recipient bed and the rich capillary network in the skin of the grafted ear. Konig's teaching seems to have been largely forgotten until the recent war. In 1941 Sir Harold Gillies (3) introduced at the Basingstoke Plastic Centre chondro-cutaneous grafts for the repair of ala defects. These are grafts of ear cartilage plus one layer of covering skin. A little later, Barrett Brown (4) extended the method to include composite grafts of the whole of the ear margin or lobule for the repair of defects in nostrils and nose tip. His results and teaching firmly re-established the use of composite ear grafts for these nasal repairs. Several extensive studies in the use of composite grafts have since been published by other workers, particularly by Dupertuis of Philadelphia (5) who, I understand, at the 1947 meeting in Memphis of the American Association of Plastic Surgeons, made reference to the use of these composite ear grafts in the treatment of digital injuries (6). I am indebted to Sir Archibald McIndoe (7) for first bringing to my notice the suggestion that composite ear grafts might be of value in traumatic amputations of the finger tip.

Technique.

A thorough toilet with 1% warm cetavlon is done by the man himself for 10 to 20 minutes. This cetavlon toilet is repeated later under the analgesia. Digital ring block analgesia and a digital tourniquet are used. Devitalised tags of soft tissue and dirt ingrained layers of the amputation stump are exercised. The bone is not touched unless its surface is ingrained with dirt; if it is this layer is nibbled off. The nail is cut back until it is about 5 mm. short of the margin of the stump in order that healing may occur along this margin before the nail grows over a scabbed and unhealed edge.

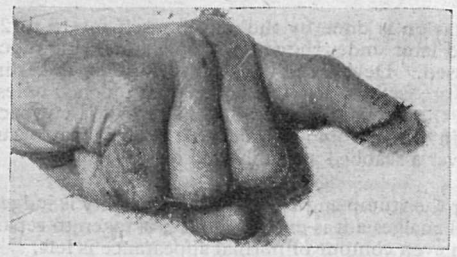
The area of ear lobule needed to cover the stump and restore pulp convexity is judged by eye and marked out in ink, under local analgesia it is excised. Care is taken to repair ear margin and lobule carefully so that an even contour of normal appearance is left.

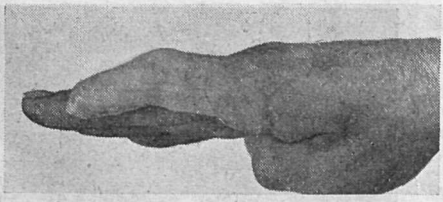


The digital tourniquet is released and dry gauze pressure applied for 2-5 minutes. If oozing continues the tourniquet is then reapplied and the graft sutured over the stump with fine silk sutures at 2 to 3 mm. intervals. Some of the fat within the graft may be filleted to make room for a projection of the phalangeal stump, (as in Case 1). Fixation is by dry gauze and zinc oxide strapping. On the release of the tourniquet manual pressure is reapplied over dressing and graft for 2-5 minutes.

Results.

In the 4 cases treated in the Accident Theatre at Guy's there have been superficial and patchy losses of the graft in 3 cases which have delayed healing for 6–8 weeks. At this stage the stumps have been tender and not everywhere mobile on the bone. The late results in 3 cases have been supple, non-tender stumps stable in work and in cold. The return of sensation has been poor. The skin of the graft is pinker and laxer than normal pulp skin. The fourth case done 2 weeks ago was an edge-to-edge take and healed in a week.





None of these patients have minded the loss of ear lobule. By chance the first two patients treated in this way were done so in the same week and lived in the same street. They were happy about their treatment, but they both stated that their wives took marked exception to their returning home from work with a missing ear lobule.

Comment.

In my hands composite ear grafts are less certain for finger stump repairs, in terms of uniform take and quick healing, than in nostril repairs. The patchy areas of loss in three cases have probably been due to inadequate hæmostasis. The end result has been a soft symptomless stump without further shortening, but with poor sensation. From the point of view of sensation, the method does not compare with the results obtained, either by the use of a local flap of finger tissue to cover the bone (when one is available) leaving a secondary pulp defect to be covered by a split "skin free" graft, or by thenar and palmar flaps.

On the basis of this experience it is suggested that a composite ear graft in men can be a useful alternative short term method of repair for finger stumps, when it is important to avoid shortening and when a hospital bed is not available for a pedicle flap repair.

References.

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2. *Davis, Staige. Plastic Surgery. Henry Kimpton*, 1919.
3. *Gillies, Sir Harold. B.J.S. xxx* 305.
4. *Barrett Brown, J., and Cannon, B. S.G.O.*, 82, 253–255, 1946.
5. *Dupertuis. Plastic and Reconstructive Surgery*, 2, 135–144, 1946.
6. *Mowlem, Rainsford. Personal communication*, 1948.
7. *McIndoe, Sir Archibald. Communication in discussion at B.A.P.S. meeting*, 1948.

Reviews

The Rhesus Factor. By G. FULTON ROBERTS. 2nd Edn. Heinemann. *Price* 3*s.* 6*d.*

This booklet, brought up-to-date and slightly enlarged, contains all that is required for the general practioner or the obstetric specialist to understand all that is understood about this problem. It cannot be too highly praised for its clear exposition.

H.A.R.

Cystoscopy and Urography. By J. B. MACALPINE. 3rd Edn. John Wright & Sons. *Price* 63*s.*

It is thirteen years since the last edition of this outstanding work appeared. This new edition not only maintains the high standard of its predecessor but its value has been enhanced by much new material and many new and excellent illustrations.

A noteworthy addition is an excellent chapter on the pathology of renal tuberculosis. The following subject matter also merits special attention; the common and rarer forms of cystitis, Tumours of the Bladder, Congenital Abnormalities, Prostatic Hypertrophy and the excellent section covering urography.

This complete work containing so much information of practical value is strongly recommended to general surgeon and specialist alike.

House Appointments

SEPTEMBER 1st, 1949

GUY'S HOSPITAL

HOUSE SURGEONS

Firm.	A.H.S.	H.S.
Sir Heneage Ogilvie and Mr. Blackburn	Mr. R. G. Nicholson	Mr. C. H. Kinder* (3 months)
Mr. Massie and Mr. Wass	Mr. O. L. Thomas	Mr. D. O'Keeffe* (6 months)
Mr. Eckhoff and Mr. Lawrie	Mr. J. F. Soothill	Mr. J. Vance (3 months)
Mr. Atkins and Mr. Glover	Mr. W. J. C. Symonds	Mr. N. H. Porter (6 months)
Mr. Slesinger	Mr. J. D. Morris (Appointed for 6 months; first 3 months as A.H.S.)	

RESIDENT OBSTETRICIANS.

1.5.49—31.10.49 ..... Mr. H. W. Trusted*
1.7.49—31.12.49 ..... Mr. A. W. Banks*
1.9.49—28. 2.50 ..... Mr. J. A. Bulleid*

OUT-PATIENT OFFICERS.

Mr. I. E. Evans, Mr. T. B. Brewin, Mr. G. W. Scott, Mr. A. J. Salmon (3 months)

HOUSE PHYSICIANS.

To Sir John Conybeare and Dr. Hardwick	Mr. J. H. Evans, Mr. R. W. Glem	(6 months).
Dr. Boland and Dr. Baker	Mr. A. A. Craigen, Mr. K. M. S. Hume	(3 months)
Dr. Hampson and Dr. Kauntze	Mr. D. C. Deuchar, Mr. T. E. Jeffreys	(3 months)
Dr. Douthwaite and Dr. Mann	Mr. J. D. Williams, Mr. R. D. Allen	(6 months)
NEUROLOGICAL HOUSE PHYSICIAN	Mr. T. R. L. Finnegan*	(6 months)
CHILDREN'S HOUSE PHYSICIANS	Mr. K. A. A. Campbell*	(3 months)
	Mr. B. G. B. Christie	(6 months)
DERMATOLOGICAL HOUSE PHYSICIAN	Vacant.	
GENITO-URINARY HOUSE SURGEON	Mr. C. J. G. Menzies	(3 months)
HOUSE SURGEON TO THE THORACIC UNIT	Mr. E. F. Soothill	(3 months)
OPHTHALMIC HOUSE SURGEON	Mr. H. L. Blackhouse*	(3 months)
THROAT AND EAR HOUSE SURGEON	Mr. O. F. Conran	(3 months)

RESIDENT JUNIOR CLINICAL PATHOLOGISTS. Vacant (2).

ORPINGTON	General House Surgeon	Mr. M. C. H. Jackson
	Ear, Nose and Throat House Surgeon	Mr. H. E. G. Dyer
SOUTHERN	House Surgeon	Mr. G. F. Barnes*
JOYCE GREEN	General House Surgeon (including Gynæcology)	Mr. P. B. Poole
PEMBURY	House Surgeons	Mr. A. E. McLauchlan
		Mr. D. G. Chalmers
	House Physicians	Mr. D. N. H. Owen
		Mr. J. T. Woodall

*Ex-Service.

Guy's Hospital Rugby Football Club

FIXTURE LIST SEASON 1949–50.

Date.		*Ground.*	*Opponents.*
1949.			
September	17th.	H.O.P.	Catford Bridge.
,,	24th.	H.O.P.	Blackheath.
October	1st.	Portsmouth	United Services, Portsmouth.
,,	8th.	H.O.P.	Aberavon.
,,	15th.	H.O.P.	Bedford.
,,	22nd.	Plymouth	Plymouth Albion.
,,	24th.	Paignton	Paignton.
,,	29th.	Dulwich	Old Alleynians.
November	5th.	H.O.P.	Old Blues.
,,	9th.	H.O.P.	Cambridge University.
,,	12th.	Birkenhead	Birkenhead Park.
,,	19th.	Old Deer Park	Rosslyn Park.
,,	21st.	H.O.P.	University College, Dublin.
,,	26th.	South Croydon	Old Whitgiftians.
December	3rd.	H.O.P.	Coventry.
,,	10th.	Thames Ditton	Old Cranleighans.
,,	17th.	Moseley	Moseley.
,,	31st.	Headstone Lane	Old Millhillians.
1950.			
January	7th.	H.O.P.	Old Merchant Taylors.
,,	14th.	H.O.P.	Wasps.
,,	21st.	TWICKENHAM	ENGLAND *v.* WALES.
,,	28th.	H.O.P.	Devonport Services.
February	4th.	Coventry	Coventry.
,,	11th.	H.O.P.	Metropolitan Police.
,,		TWICKENHAM	ENGLAND *v.* IRELAND.
,,	18th.	Aberavon	Aberavon.
,,	25th.	Rectory Field	London Irish.
March	4th.	Herne Hill	London Welsh.
,,	11th.	Thames Ditton	Old Paulines.
,,	18th.	H.O.P.	Gloucester.
,,		MURRAYFIELD	ENGLAND *v.* SCOTLAND.
,,	25th.	Llanelly	Llanelly.
April	1st.	H.O.P.	Richmond.
,,	8th.	Easter.	

INTER-HOSPITALS RUGBY FOOTBALL CUP

1949-50.

Middlesex / Charing Cross — 2.45. 16th Feb.

Guy's / St. Thomas' — 2.45. 7th March

Westminster — 2.45. 21st Feb.

Semi-final

2.45. 7th Feb.

St. George's / U.C.H. — 2.45. 9th Feb.

St. Mary's — 2.45. 23rd Feb.

St. Bartholomew's / King's College — 2.45. 15th Feb.

London — 2.45. 28th Feb.

Semi-final — 2.45. 9th March

Final — 3.0 p.m. 29th March

All matches will be played at Richmond.

Correspondence

"Panoramic" Paintings of Guy's

SIR,—While greatly enjoying the illustrations of, and editorial and other comment on, the three new "panoramic" paintings of Guy's, I have been waiting impatiently to learn if and when they will be available as reproductions. However greatly expert opinion may vary as to their æsthetics, there can be little doubt that these pictures evoke memories of the rich and ever-varied atmosphere of the hospital more vividly than any formal prints or etchings, however excellent; and I feel sure there must be many old Guy's men besides myself, now many miles or years asunder from their "most kindly nurse," who would welcome copies of them on their walls.

Yours, etc.,

DOUGLAS LAMB.

University of Minnesota,
Student Health Service,
Minneapolis.

Sports Reports

SIR,—I read with great interest Dr. Wacher's letter with regard to "Reports upon Games." For 25 years before the war, I had the pleasure of keeping statistics of the "Rugger" 1st XV. games, and at the end of each season, a graph was prepared with data showing full details of all the games. All this information was obtained from the reports given in the *Gazette* when, as Dr. Wacher states, not only a report, but names of the players, etc., was given. After the war, I hoped to continue these records but found that reports of the games very poor, in fact, many games were not reported at all, not even results given, and attempts to obtain the required information from club officials met with no success, dispite the fact that I believe Rule 14 (Clubs' Union Rugby Section) states, "The Secretary shall keep a record of all matches and of the men who have played in each match." I feel it is a great pity these records could not have been carried on in view of Guy's position in the "Rugger" world.

I do hope Sports reports, particularly the "Rugger," next season will be reported as in pre-war days, now a little more space is available.

Yours etc.,

ROY C. HOLLOWAY,
Hon. Life Member, Clubs' Union.

8a, Montacute Gardens,
Tunbridge Wells.

Guy's Diary

SEPTEMBER

ACADEMIC

Exhibition. Surgical Department. "Diseases of the Hip in Children."

1st. 4.30. X-ray Demonstration. Gordon Museum.

5th. 12.00. Surgical Staff Conference. Clinical Theatre.
1.00. Mr. Reading. Clinical Lecture. "Facial Paralysis."
3.30. Demonstration of Skin Diseases. Dr. Forman. Preclinical Classroom.

6th. 12.0. Neurological Demonstration. Preclinical Classroom.

8th. 1.00. Sir Heneage Ogilvie. Clinical Lecture. "Acid and Ulcers."
4.30. X-ray Demonstration. Gordon Museum.

10th. 10.00. Professor A. M. Boyd, Royal Infirmary, Manchester. Surgical Departmental Round. Clinical Theatre.
1.00. Mr. Gibberd, Clinical Lecture.

12th. 3.30. Demonstration of Skin Diseases. Dr. Forman. Preclinical Classroom.

SPORT

3rd. 2.30. 1st XI. *v.* Kenley (Away).

Sport

CRICKET

DEVON TOUR

Guy's *v.* Chudleigh C.C.

At Chudleigh. Result—Lost.
8th August, 1949.

Guy's 105; Chudleigh 106—7

The pitch was very heavy and slow and Guy's were put in to bat. Lipington and Gray opened and put on 13 in the first two overs, both batting very confidently. But in the third over Gray got in front of his wicket and was l.b.w. with the score at 17. Lipington continued to hold his own, but at the other end a regular procession followed. The slowness of the pitch was unfamiliar after the dry summer, and the batsmen were unable to stay at the wicket long enough to get accustomed to it. Lipington kept going steadily until he was caught with wicket down with the score at 99. He had made 54.

Chudleigh started carefully, but the accurate bowling of Russell claimed two wickets with the score at 17. The Guy's fielding kept the runs to a minimum and 5 wickets were down for 85, two more going to Russell. Dr. Walters, batting No. 3, was scoring steadily the whole time, and saved his side from a possible collapse. Russell's bowling analysis read 12. 4. 34. 4.

Guy's *v.* Exmouth C.C.

At Exmouth. Result—Won.
9th. August, 1949.

Guy's 169; Exmouth 54.

Guy's batted first on a firm wicket, with Russell and Lipington opening. Russell made 3 out of 22 before being caught. Gray came in and the score was taken to 58 before he ran himself out. With the score unaltered at 58 three more wickets fell and the situation became a little grim. Fearn and Smith broke the procession, and the score stood at 109 for 9 when Dickens came in to partner Fearn. Now Dickens does not possess a great range of attacking strokes; he plays a waiting game—for the ball to hit his bat. With great concentration he mastered the attack on his wicket, while Fearn, scoring freely at the other end, was taking all the bowling he could. And so the score was taken to 169, Dickens making 6, including one boundary from a very late cut through the slips, before being bowled by a very good leg break. Not out with 83 runs, Fearn had played a match-saving innings.

Exmouth never succeeded in getting going, with the bowling always on top and the fielding tight. Gray, Smith and Russell claimed the first three wickets for 34 runs, and the last five wickets fell for the addition of 5 runs. Tweed, 64. 3. 10. 3. Russell 9. 3. 17. 3. The wicket-keeping of Matthews was notable, especially for many difficult stops on the leg side.

Guy's *v.* United Services, Devonport

At Mount Wise. Result—Lost.
10th. August, 1949.

United Services 104; Guy's 103.

The U.S. batted first and lost two wickets for 10 runs, one being run out after a good return from Lipington at cover. The third wicket was also run out, when an overthrow to the wicket-keeper was well backed up by Tweed. Smith dealt with the tail summarily, taking three wickets in four balls. He was bowling fast, and making them come in off the pitch very quickly. His analysis was 9. 2. 12. 4.

Guy's started well, with an opening stand of 32 by Russell and Lipington, but at that score three wickets fell. Prentice add 22 to the score, to bring it to 81 for 7. Cahill and Matthews each added 9, and the 10th wicket fell at 99. Tweed hit a four, but with two runs needed to win, played the ball gently back into the bowler's hands.

Guy's *v.* Plymouth C.C.

At Plymouth. Result—Lost.
11th. August, 1949.

Guy's 96; Plymouth 97—4.

Again an opening stand of 34 became a case of 53 for 4. The bowling was very steady and good in length, and the slow pitch helped the spin. The Plymouth fielding was really excellent and not a chance was missed. Jones was out to a very hard catch back to the bowler, and Prentice to one at forward short-leg. Smith made a useful 23 not out to give the score just a semblance of respectability.

Guy's fielding was the tightest yet and Plymouth lost their second and third wickets both run out. The fourth wicket stand remained unbroken, though a catch to Prentice by the sight-screen behind the bowler was dropped with the score in the eighties. This lapse was followed by two more hard chances in the field, but the batsmen were going for the runs and the result was not in doubt for long.

Guy's *v.* Devon Dumplings

At Exeter County Ground. Result—Draw. 12th. August, 1949.

Guy's 251—6 ; Devon Dumplings 181—5.

Russell and Lipington opened the batting and proceeded cautiously against some very steady bowling. The pitch was very fast, and the ball swinging considerably.

Lipington was out for two in the twelfth over with 20 on the board. While Russell kept his end going with some safe and steady batting, wickets fell at intervals the other end until five wickets were down for 93. Prentice came in and with Russell put on 147 for the fifth wicket. Russell was well on top of the bowling and went from 50 to his century with 32 in boundaries, including two sixes in the same over. He made 132 before being bowled by Parker. Shortly afterwards the innings was declared, with Prentice 65 not out.

The Dumplings, with a strong batting side, and with 10 minutes less batting time than Guy's, stood a fair chance to get the runs. But accurate bowling by Smith and Russell pegged them down. Russell's first ten overs gave away only 15 runs for one wicket and Smith 25 for one. Russell continued to bowl unchanged, except for two extravagant overs by Prentice, throughout the innings.

The Dumplings were so far behind the clock, that even the forceful batting of Dr. Caldwell in the last half-hour did not make a draw any less inevitable.

Guy's *v.* Paignton C.C.

At Paignton. Result—Lost. 13th August, 1949

Paignton 214—3 ; Guy's 159.

Paignton chose to bat, and opened with Dawson and Mullet, who put on 54 for the first wicket. Waldron followed Mullet and was out with the score at 57. Dawson and Coombe put on 94, both scoring fast and safely. The fielding gave little away, but the bowlers could not restrain the batsman, and a good deal of leather hunting went on. Dawson had made 115 not out when the innings was declared.

Russell and Lipington opened but with the score at 1, Lipington was out l.b.w. Prentice came in and batted steadily with Russell to put on 47 for the second wicket. The peace of a game of bowls in progress behind the sight-screen was momentarily shattered by a six from Russell, and from then on he took the bowling in hand. In partnership with Fearn he took the total from 58 to 114. Fearn had been playing with unwonted care for half and hour, then was caught off the first ball he played in his normal aggressive manner. Smith added 16 and at 149 Russell was out l.b.w., having made 89 runs which the crowd enjoyed as much as the Guy's team.

With quarter of an hour to go, and three wickets to fall, they might have played for a draw. But the batsmen went for the 66 runs needed to win. They scored 10 of them before being all out. Dickens remained undefeated with 1 run.

SAILING

Universities and Schools Races

There was a record entry of 46 for the Universities and Schools races, held in Dragons on the Gareloch, from August 15th–19th. Racing was very efficiently organised by the Mudhook Yacht Club, seven rounds being sailed by each class.

Oxford won the Young Cup from the holders, U.H.S.C., and fifteen other entrants in the Universities Class, while Lovells won the Clark Cup in the Schools Class.

U.H.S.C. Team :—
P. B. Clark (Middlesex).
I. Bradbeer (Guy's).
I. McMullon (St. Thomas's).

The leading positions in the Universities Class were :—
1st. Oxford.
2nd. Dublin.
3rd. Glasgow.
4th. U.H.S.C.
5th. Cambridge.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

Applications are invited for the appointment of **Registrar (Whole-time) to the Neurological Department** for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be forwarded to him not later than 29th August, 1949.

Applications are invited for the appointment of **Senior Registrar to the Ear, Nose and Throat Department** for one year as from 1st October, 1949. Forms of application are obtainable from the Dean, Guy's Hospital Medical School and should be forwarded to him not later than 31st August, 1949.

Applications are invited for the post of **House Physician in the Dermatological Department.** Duties to commence on 1st September. Salary to be in accordance with the new Terms and Conditions of Service, as follows :—

£350 per annum for the first six months.
£400 per annum for the second six months.
£450 per annum for the third and any subsequent period,

less deduction at the rate of £100 per annum for board and lodging.

Applications should be lodged in the Superintendent's Office not later than August 24th.

Applications are invited for the post of **Junior Clinical Pathologist.** Duties to commence on October 1st, 1949. Salary in accordance with Terms and Conditions of Service of the Ministry of Health. Applications should be lodged with the Superintendent not later than September 15th.

JUNIOR STAFF APPOINTMENTS

The following appointments to the Junior Staff have been made by the School Council as from 1st October, 1949, for the period stated :—

Assistant to the Director of the Student Health Service.
N. Southwell, M.D., for one year.

Junior Assistant to the Director of the Department of Medicine.
R. E. Irvine, M.R.C.P., for one year.

Tutor in charge of the Preliminary Clinical Period Class.
J. C. Houston, M.D., for one year.

Assistant Lecturer in the Department of Morbid Anatomy and Histology (Gull Student).
J. O. Laws, M.R.C.P., for two years.

Demonstrator in the Department of Morbid Anatomy and Histology.
D. A. Osborn, M.B., B.S., for one year.
E. A. Wright, M.B., B.S., for two years.

Assistant Lecturer in the Department of Chemical Pathology.
R. W. R. Baker, B.Sc., for one year.
A. Tickner, M.B., B.S., for one year.

Demonstrator in the Department of Chemical Pathology.
C. L. Joiner, M.R.C.P., for one year.

Assistant Lecturer in the Anatomy Department.
I. D. Henderson, F.R.C.S., for one year.

Demonstrator in the Anatomy Department (Whole-time).
B. H. Pentney, M.R.C.S., L.R.C.P., for one year.
A. V. Poots, M.B., B.Ch., for one year.
J. Wilks, F.R.C.S., for one year.

Demonstrator in the Anatomy Department (Part-time).
W. H. Tulley, B.D.S., for one year.

Demonstrator in the Physiology Department.
D. J. Anderson, B.D.S., M.Sc., for two years.
I. Macdonald, M.B., B.S., for two years.

Assistant Lecturer in the Biology Department.
B. J. Rickard, B.Sc., for one year.

Assistant Lecturer in the Chemistry Department.
M. E. Foss, Ph.D., for one year.
P. R. Rowland, M.Sc., for one year.

Demonstrator in the Chemistry Department.
I. G. Anderson, B.Sc., for one year.

Assistant Lecturer in the Physics Department (Whole-time).
A. Nightingale, M.A., for one year.

Assistant Lecturer in the Physics Department (Part-time).
A. H. Walker, Ph.D., for one year.

Half-time Assistants to the Director of the Conservation Room.
H. S. M. Crabb, B.D.S., for one year.
J. B. Kirkwood, B.D.S., for one year.
A. D. Robinson, B.D.S., for one year.

Demonstrators of Operative Dental Surgery.
G. S. Loader, F.D.S., for one year,—1 session per week.
C. I. Hagger, L.D.S., for one year—2 sessions per week.
J. G. Hancock, B.D.S., for one year—2 sessions per week.
T. J. Hancock, B.D.S., for one year—3 sessions per week.
R. J. Hart, B.D.S., for one year—3 sessions per week.
P. J. Hill, L.D.S., for one year—3 sessions per week.
N. A. Power, L.D.S., for one year—3 sessions per week.

Half-Time Assistant in the Department for Children.
W. J. Tulley, B.D.S., for one year—6 sessions per week.

Half-Time Assistants to the Professor of Dental Prosthetics.
G. F. Dyer, B.D.S., for one year.
R. D. W. Stileman, L.D.S., for one year.

Demonstrators in Dental Mechanics and Prosthetics.
R. D. Gain, L.D.S., for one year—3 sessions per week.
M. Malleson, L.D.S., for one year—3 sessions per week.
A. Rand, L.D.S., for one year—2 sessions per week.
R. J. Wheatley, L.D.S., for one year—2 sessions per week.

Director of the Department of Preventive Dentistry (Half-Time).
R. D. Emslie, B.D.S., for one year.

Half-Time Assistant in the Department of Preventive Dentistry (Half-Time).
A. A. W. Fooks, B.D.S., for one year—6 sessions per week.

Half-Time Demonstrator in Special Anatomy and Histology.
P. C. Grummitt, B.D.S., for one year—6 sessions per week.

Half-Time Assistant for the Teaching of Extractions and Minor Oral Surgery.
D. F. L. Cook, L.D.S., for one year—6 sessions per week.
B. G. E. Donner, B.D.S., for one year—6 sessions per week.

PASS LIST

UNIVERSITY OF LONDON

M.B., B.S.

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES.

(FOR INTERNAL STUDENTS)

June, 1949.

G. H. Anderson	H. R. B. McCauley
J. B. Anderson	A. G. MacDiarmid
V. H. Bartley	J. McKenna
A. J. Belsham	R. J. S. Milton
J. R. F. Boger	O. Morton
J. D. Broome	S. M. Mullally
D. V. Burke	D. B. A. Ofomata
I. Caldwell	B. K. Oliver
L. J. Cheeseman	M. R. Phillips
C. D. Chilvers	A. N. Pollock
B. B. Collins	J. A. Pollock
G. W. Cowley	E. C. Reynard
J. L. Croft	H. W. Riddolls
H. C. Cummins	O. H. Shaheen
D. J. Davies	P. S. Smith
G. H. Daw	D. L. Smithson
I. U. Fraser	P. S. Stack
M. C. Gie	J. C. Stephenson
I. M. Hauldren	M. D. Surtees
D. P. Honey	D. R. Taylor
K. S. Jap	R. C. C. Thompson
P. Jenkins	E. E. D. Tomlin
D. W. S. Klee	C. Vowles
J. V. V. Lewis	K. P. Walker
K. L. Lowings	D. J. Wicker
W. S. Lund	J. H. P. Willis
E. W. Lunn	C. F. A. Younger

The following Higher School Candidates have qualified for exemption from the First Medical.

H. R. Bissoon Dath	K. E. Howells
J. F. Gill	A. J. Pearson
A. C. Graham	J. M. Sadler

M.B., B.S.

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

(INTERNAL STUDENTS)

July, 1949.

V. Ainsworth	P. E. Kapff
S. S. Barker	A. V. Large
C. V. Bullen	E. N. McKenzie
B. J. Cremin	G. A. Marin
L. M. Davis	J. M. Montague
J. Dennis	E. Morrison
L. L. Emery	F. G. M. G. Myer
A. G. E. Fung-a-Fat	F. E. N. Roper
D. J. Green	J. E. Scriven
P. M. Hardiman	W. E. D. Smyth
D. C. Harris	P. F. Stebbing
E. G. Haydon	F. L. D. Steel
P. O. Hirsch	A. E. Strigner
G. J. John	

M.D. EXAMINATION.

July, 1949.

Branch I.—(Medicine).

M. F. Hart G. H. T. Lloyd

B.Sc. (PHYSIOLOGY)

First Class Honours.

R. J. Shephard

Second Class Honours.

J. Ernsting P. H. Staple, B.D.S.

SECOND EXAMINATION IN DENTAL SURGERY.—PART I.

July, 1949.

F. Allan	D. H. MacLeod
E. J. Artes	G. Maggs
D. J. Chant	R. H. Pownall
D. L. H. Clark	N. H. Reeves
A. Gibson	T. Smith
G. L. Hunter	R. W. Willcocks

B.D.S.

SECOND EXAMINATION IN DENTAL SURGERY.—PART II.

July, 1949.

E. M. Bearn	R. V. S. Muscat
A. J. Bligh	N. E. Price
R. E. Collinson	I. I. Singer
R. J. G. Day	J. Stott
C. H. Dexter	J. S. Tisdall
S. S. R. Earl	J. C. Walby
P. Elias	W. C. Whaites
B. A. Embleton-Smith	M. L. Wilder
A. G. Jennings	W. J. P. Wilkie

B.D.S.

THIRD EXAMINATION IN DENTAL SURGERY.

July, 1949.

Honours.

P. T. Grimer

Distinguished in Medicine, Surgery, Pathology and Bacteriology, Pharmacology and Dental Surgery.

Pass.

P. Glazebrook	P. J. A. Lawrence
M. Kaye	L. A. Rees
M. M. Keen	J. D. R. Shaw

ROYAL COLLEGE OF PHYSICIANS OF LONDON

July 1949.

M.R.C.P.

E. M. M. Besterman	G. O'Gorman
J. E. Blundell	B. E. R. Symonds
J. D. Everall	D. G. Vulliamy
A. J. Karlish	E. A. Wright
K. A. Newton	

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.R.C.S.

PRIMARY EXAMINATION.

July, 1949.

J. Crossley	H. A. Philcox
M. Kugler	M. M. El Shinnawi
I. MacDonald	K. L. Wilson

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

July, 1949.

Surgery.

*R. J. Aspinall	*C. J. G. Menzies
*M. P. M. Coupland	I. A. W. Scott
E. W. Melia	

Pathology, Bacteriology and Forensic Medicine.

J. T. Cecil	D. J. Joubert
A. K. Doust	E. W. Melia
M. C. Gilbert	J. D. Morris
*M. C. H. Jackson	J. S. G. P. Stableford

Medicine.

A. K. Doust	D. H. Le Clus
A. C. de B. Eksteen	J. D. Morris
M. C. Gilbert	J. S. G. P. Stableford
*M. C. H. Jackson	P. A. Van der Merwe

Midwifery.

*H. E. G. Dyer	P. B. Poole

* Have completed the examination.

ROYAL SOCIETY OF MEDICINE

F. N. Doubleday, F.D.S., has been elected President of the Odontological Section and Member of the Council of the Society.

CHANGES OF ADDRESSES

A. G. Bearn, M.B., B.S., British Postgraduate Medical School, Hammersmith Hospital, W.12.

W. G. Gill, F.R.C.S., Munstead Belt, Godalming, and Telford Lodge, L. Edgeborough Road, Guildford (Consulting Room). (Tel.: Godalming 162 and Guildford 4989.)

R. A. Keable-Elliott, M.B., B.S., Southend General Hospital, Southend-on-Sea.

T. C. L. Parry, M.B., B.Ch., 42a, Mount Park Road, Ealing, W.5.

D. Redpath, L.M.S.S.A., *The Hollies, Sandpit* Lane, St. Albans, Herts. (Tel.: St Albans 1071.)

L. J. Wallace, L.D.S., R.C.S., 25, Stafford Terrace, Kensington High Street, W.8. (Tel.: Western 9466.)

R. D. C. Hart, M.B., B.S., Nore Marsh Farm, Wootton Bassett, Wilts. (Tel.: 176.)

S. S. Grove, M.R.C.S., L.R.C.P., Okombainbi, P.O. Okahandja, South West Africa.

BIRTHS

BLOCKLEY.—On August 8th, 1949, at Pembury Hospital, to Doreen (née Haselwood), wife of Clive H. Blockley, L.D.S. R.C.S.—a sister for Martin and Judith.

DENTON.—On August 17th, 1949, at St. David's Hospital, Cardiff, to Edith (nee Sander-Luer), wife of Paul H. Denton.—a son (Nicholas).

MARRIAGES

PARKER—BURLEIGH.—On August 6th, 1949, at St. Peter's Church, Birch, Essex, John A. R. Parker, M.B., B.S., to Sybil B. Burleigh.

PARKES BOWEN—ROBINSON.—On 25th June, 1949, at All Saints, Sedgley, David Parkes Bowen, M.B., B.Chir., son of Mr. and Mrs. Malcolm Bowen, of Woodsetton, to Sheila Wendy Robinson M.S.R., only daughter of Mr. and Mrs. R. J. Robinson, of Wolverhampton.

DEATHS

DEUCHAR—On July 17th 1949, James Lennox Deuchar, L.D.S., R.C.S. Eng., of 137, High Street, Slough.

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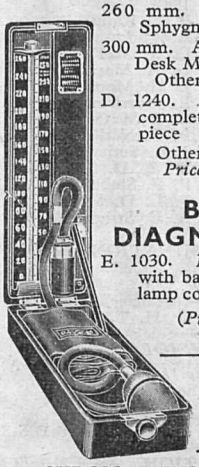

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GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

MANNERS, like good clothes, are "more easily recognised than described." Though they so often form the subject of disciplinary addresses at school they should be sufficiently unobtrusive to escape even mention among an undergraduate population and certainly among the members of a more mature community. Yet Asher has seen fit recently to cite bad manners as among the seven cardinal sins of medicine, so to pause a moment for self-examination might well yield good results.

In a previous Passim, Sir Herbert Eason was quoted as saying that "a patient judges the Hospital on two counts, the porter who greets him at the front lodge, and the nurse who looks after him in the ward." By these standards Guy's can have little cause for reproach. Nevertheless of late there has been an unfortunate tendency for trolleys, usually empty but occasionally bearing patients, to be handled uncommonly like railway trucks in a goods yard. And the nurse quite often finds, especially these hot and sultry days when legs ache and tempers fray, that patients' apparently unreasonable requests so easily provoke a thoughtless retort. A levity or excitement aroused by otherwise welcome distractions may also prove difficult to restrain in the presence of the sick.

If such small lapses are worthy of mention the more so are those indulgences to which others are prone. The Front Surgery, for example, is not the place, by day or night, in which to discuss airy nothings in loud and negligent tones or through which to stroll haphazardly while the afflicted seek attention or their companions anxiously await. The doorway of Hunt's House may be the traditional meeting place for rounds, but that is no reason to congest it to the utter inconvenience of everyone else trying to enter or leave. The wards themselves are the "chambers of the sick," to use Heberden's phrase. A solemn or mournful atmosphere is certainly to be avoided. That is no reason for strolling between the beds discussing the "dates" and amorous excursions for the week or regarding the occupants merely as interesting cases to be swooped upon in the furtherance of scientific study.

The clinical side apart, is there any reason why at a post-mortem demonstration a few myopic spectators should crowd over the central theme to the complete exclusion of others equally interested? When people attending clinical lectures are unavoidably late or find it equally imperative to depart early, could they not do so with some regard for others rather than by stamping about and banging doors? And may we ask that those who wait outside should converse in suitable whispers instead of taking the opportunity to practise their Marble Arch oratory? So we might go on; examples, unfortunately are numerous. None, individually, is a crime, but collectively they reflect a selfishness that attracts no credit.

At an autopsy the presence of any member of the senior staff is always welcome. An expression of his observations or opinions to the assembled audience is then more appreciated than a whispered conversation with the pathologist which does little more than delay the progress of the dissection. The patient in the bed or at the clinic—"all are anxious in the presence of the doctor" as Coope observes—boasts a soul as well as a body. The latter affords a convenient basis for the elicitation of signs and the study of disease. But this should not be carried out oblivious of the possessor's feelings. He may, admittedly, be receiving treatment and attention which, by monetary standards, are far in excess of his insurance contributions Nevertheless, he is an individual and,

unless proved to the contrary, worthy of understanding. If he should appear dull, unresponsive, loquacious or just plain silly, let us remember that to the limit of his endowed mental faculties he is doing his best. The initial greeting, therefore, should never be neglected, co-operation for the examination should be invited and, so far as possible, the imperfections accepted. Thereafter, the discussion of the possible and frequently alarming pathologies and prognoses are best conducted away from the bedside, not overlooking the fact that another patient in the same ward to whom the firm adjourns can also hear and, what is more, can and does transmit impressions, often erroneous, to the previous subject of the discourse.

From time to time the complaint is raised that since physicians and surgeons discarded the pomp, panache and majesty of bygone years they have no longer been accorded that respect which is their due. A return to airs and graces is wholly undesirable. Those in the profession who lead at Guy's so obviously command our admiration. They do so, not simply by the way in which they discharge their technical functions but because "a life of self-less well-doing moulds the nature of the person who lives it." By this means, inspiration is derived by those who follow and a deference shown which never descends to obsequiousness.

Congratulations are offered to Mr. A. R. F. Thompson and Mr. R. O. Holland on their appointment as Assistant Dental Surgeons to the Hospital. Both are Guy's men. Mr. Thompson, after qualifying B.D.S. in 1930 and being awarded the Newland-Pedley gold medal and prize, undertook post-graduate study at the North-Western University, Chicago. The following year he was Montgomery Ward Scholar. Thereafter he held various positions in the Dental School, interesting himself mainly in prosthetics and operative dental surgery, and in 1939 he took the conjoint qualification in medicine.

Mr. Holland obtained his L.D.S. in 1935 and his L.R.C.P., M.R.C.S. in 1938. He, too, has held various appointments in the Dental School. During the recent war he served as Surgeon Lieutenant Commander in the R.N.V.R.

OVER the week beginning 15th August when the Derry Gardens were open in aid of the Hospital Comforts Fund, a total sum of £405 7*s.* 6*d.* was collected. This figure constitutes a record for any hospital engaging in a similar venture and reflects very great credit on the Ladies' Association, responsible for the entire organisation.

AN eminent neurologist was observed last Saturday in rapt contemplation of a new and impressive Austin car lately acquired by a surgical colleague and displayed in the fore-court of the Hospital. It is not yet reported whether he found the tone satisfactory, the power undiminished, sensation unaltered or the reflexes present and equal.

STRANGE and loud machinery murmurs to be heard on the stairway of the medical block have lately excited considerable curiosity. On the authority of those concerned a cold-room is apparently being fitted out and set in operation. It will be employed, not for any catering purpose, but to provide controlled conditions of temperature under which the action of particular drugs can be studied in the treatment of angina.

A JOINT meeting of the National Association for the Prevention of Tuberculosis and the Society of Medical Officers of Health will take place in the B.M.A. House, Tavistock Square, W.C.1, on Thursday, 15th September, 1949, at 2.30 p.m. Professor R. H. Parry will be in the chair.

The object of the meeting is to exchange views and experiences on social and after-care arrangements by local health authorities under the National Health Service. Speakers will include Sir Alan Daley, London County Council, Dr. G. W. H. Townsend, Buckinghamshire County Council, Dr. W. Alcock, Burton-on-Trent, Dr. Neville Irvine (B.C.G. vaccination), and Miss Anne Topley, Care Almoner, Surrey County Council.

Morbid Significance of Modern Verse

By H. St. H. VERTUE.

I.

" The greatness of wit, by which the poetic talent is here chiefly to be understood, manifests itself in the admirable balance of all the faculties."—LAMB.

THE word poetry has a specious resemblance to poetria, a poetess, but in reality it comes through the French and means the making of verses, or more often the verses themselves. It is well recognised that not all verses are poetry.

O Sire of Song! Sonata-king! Sublime and loving master;
The sweetest soul that ever struck an octave in disaster,

lines addressed by one Eric Mackay to Beethoven, are not poetry, because the writer has utterly failed to accomplish what he set out to do. But neither is this sample from Religio Laici poetry, although Dryden wrote it.

The Deist thinks he stands on firmer ground,
Cries ηὕρηκα, the mighty secret's found:
God is that spring of good, supreme and best,
We made to serve, and in that service blest;
If so, some rules of worship must be given,
Distributed to all alike by Heaven, etc.

Here one sees that there is wanting that something that distinguishes poetry from rhymed metrical prose, the anima animae, the soul of the soul, the thing that truly is poetry. To find a pure specimen I have only to open the book I happen to be reading, Southey's Thalaba, and begin at the beginning.

How beautiful is night!
A dewy freshness fills the silent air,
No mist obscures, nor cloud, nor speck, nor stain,
Breaks the serene of heaven;
In full-orbed glory yonder Moon divine
Rolls through the dark blue depths.
Beneath her steady ray
The desert circle spreads,
Like the round ocean girdled with the sky!
How beautiful is night!

Although Southey is not a poet of the front rank, he can give us through the medium of simple words that something that sends a feeling of awe and lifts us from a world of certainty into a realm of wonder. Like Pater's Latin peasant we murmur, " Numen inest." (The godhead is here.)

In strong contrast with it here is an example of what is proffered to us as poetry to-day, chosen by opening a book on the subject at random and putting down a pencil on any spot.

Triple-lipped Apollo, I consign
Your visitation to the night,
Where, amid cavernous mislove, your orbs
Large with anticipate lust must diminish
As, beneath my smothering embrace,
The shocks your nine limbs striving to impart
Shudder into the gentle heaving of sleeping.

So this is poetry! Evidently the art has changed very much. As a whole this specimen is not coherent, the construction is faulty, the meaning is not clearly expressed and there is an ugly assonance, " lust must," which looks like a blunder but may be intentional. The metre is not constructed on any apparent plan, though the enthusiast may avail himself of his favourite resource and say that it is " sprung." (The same word also describes Smith minor's cricket bat left out in the dew to warp.) As for the matter, it is fairly typical of what is passed to us as poetry to-day, and my contention is that it is not poetry at all but an unconscious representation of a disordered mind by a person doubtless sane enough himself.

Poetry is known by feeling. It can be perceived and described, but it cannot be well defined nor comprised in a formula. Even Shelley did not venture beyond a description.

He spoke of poetry, and how
Divine it was—a light—a love—
A spirit which like wind doth blow
As it listeth, to and fro,
A dew rained down from God above;

A power which comes and goes like dream,
And which none can ever trace—
Heaven's light on earth—Truth's brightest beam',
And when he ceased there lay the gleam
Of these words upon his face.

The wind blows, as the poet says, and an Aeolian harp within responds. When poetry is felt there is a sense of exaltation, and as the spirits rise the powers of the mind quicken. Sometimes, if the sense is very strong, the breathing deepens or the skin tingles; the hair may prickle or even the lacrimal glands secrete. The feeling is one of pure and unalloyed pleasure, which is wholly beneficial and exacts no payment. Some of Shelley's similes—"a dew rained down from God, Heaven's light on earth"—and his epithet "divine" proclaim to us that poetry is akin to religion. The divine principle is perceived by the poet, is expressed in verse, or in some other medium, is greeted by the poetically inclined and reproduces in them the same feeling. Communion with Nature is essential for the production and understanding of poetry, and to this rule there is no exception. None would be likely to be adduced from the poets of our Elizabethan or Victorian ages or the great period of the Regency, but it might be objected that in the "Augustan" period there was little love of Nature. This observation would hold true of most of the renowned men of letters: Addison, Congreve, Swift and Steele were pure townsmen and no poets, Gay was only a small poet and Prior a versifier. But Pope was a poet who can give enormous pleasure to this day, and the secret of his inspiration is readily found in the fortunate child, roaming free in Windsor Forest.

Ye sacred Nine! that all my soul possess,
Whose raptures fire me, and whose visions bless. . . .
I seem through consecrated walks to rove,
I hear soft music die along the grove.
Led by the sound, I roam from shade to shade
By god-like poets venerable made.

Aside from Pope the best poets of that time, Thomson, Henry Carey and Shenstone, were country-bred and lovers of Nature, not the strongest writers it may be, but very agreeable to read. Their taste for formal correctness enhances the value of the "Augustans" to-day, when there is no taste for it at all; nevertheless this predilection was carried so far that the poetic ardour was in danger of being stifled, with results that were illuminating later on, as we shall see. Yet one must be clear that the ardour was there, at times kindling into brilliance, and with it went a genuine love of Nature.

Since those days many ills have been wrought by the industrial revolution and not the least among them is this, that by eating up the country and bringing to birth a vast urban population it has hastened the decay and disintegration of poetry, or as perhaps one should say, has been the main cause of the flight and disappearance of the Muse.

The divine principle of poetry is female, personified as a Muse, worshipped as a goddess and adored as a woman.

Pimplea dulcis! nil sine te mei
Prosunt honores.

Hitherto the quest for this goddess in our own land has been so successful that poetry has flourished here as nowhere else—but it does so no longer. It is a time of widespread incredulity, in which good verses are still being fashioned here and there, but it is rare indeed to hear them ring with the thrilling sound of genuine poetry. Who, then, is she, the goddess fled, the soul of poetry, whom poets have adored?

She is found in trackless woods, in forests and glades, in lonely haunts of the shepherd and " abodes of unearthly calm " (Munro).

Avia per nemora ac silvas saltusque reperta,
Per loca pastorum deserta atque otia dia.

She reigns on winter nights when the great South winds send the clouds sailing over the shining moon with opalescent hues. She is felt in the woods as a living presence, softly brushing by. The stealthy creaks of animals on the move are the sound of her ; the warm air is her breath ; she leans over from the West, shaking the raindrops from her hair, and fosters the earth with her bosom. Alone in his chamber, between fear and fascination, beset by noises of the night, rattling of casements and inrushing eddies of woodland air, the child lies quaking. She presides over love, birth and reproduction, all beautiful and all growing things of Nature and the parts of Man's mind that are concerned with these things, and over death also, striking fear into the heart thereby, but banishing it again with promise of peace hereafter. She is the deity of the individual man, and the poet is her mouthpiece. Law, government, warfare and all the social parts of Man's life are masculine, and from Xenophon to Mr. Churchill the instrument of statesman and warrior has been prose. In verse this masculine element is represented by the heroic and rhetorical, plentifully found in epic, ballad and drama. At one time, before classical education had declined, he that read at all read Homer or Virgil ; and, generally speaking, poetry that is skilfully interwoven of the pure gold and silver—totus et argento contextus et auro—with chivalry, heroic enterprise and stirring tales of manly courage and adventure has enjoyed unique success, and rightly so, for it shows the instinctive inclination towards a mind that is well balanced. In our own land we have among other examples the Elizabethan heritage and the priceless possession of the poetry of the Border.

O Brignal banks are fresh and fair,
And Greta woods are green,
And you may gather garlands there,
Would grace a summer queen.

Scott, now that the interest of mankind is devoted to the unsound instead of to the sound mind, is dismissed as the author of mere " jingle." Subtle, but unintended, flattery !

When gloom and apprehension prevail in the lives of men they lose their love of liberty, bunch together and look for leadership. In this state of mind they are not open to the inspiration of the goddess. Poetry is at its best when the social instinct is not exaggerated (as it is now), when men enjoy the fruits of freedom, believe in themselves and believe in their destiny.

It chanced that I was born in Victorian England, the scene of one of these great periods of fertility. The air was full of song. Tennyson was yet with us, Swinburne was the effulgent luminary and Oscar Wilde the arbiter elegantiarum. It is significent that Tennyson was well disposed towards Swinburne, admired his poetry and was calm enough about his " poisonous honey stolen from France." What moved the old poet to grandiloquent denunciation was realism.

Authors—essayist, atheist, novelist, realist, rhymester, play your part.
Paint the mortal shame of Nature with the living hues of Art.

Rip your brothers' vices open, strip your own foul passions bare ;
Down with Reticence, down with Reverence—forward—naked—let them stare.

Feed the budding rose of boyhood with the drainage of your sewer ;
Send the drain into the fountain, lest the stream should issue pure.

Set the maiden fancies wallowing in the troughs of Zolaism—
Forward, forward, ay and backward, downward too into the abysm.

Heated am I ? you—you wonder—well, it scarce becomes mine age—
Patience ! Let the dying actor mouth his last upon the stage.

Invective so magnificent as this is apt to carry one away ; but truth to tell a little realism does us good and at this particular time was needed. Prudery, the besetting sin of the

Victorians, is an unpleasant vice and a great obstruction to thought, and we owe it to the realists that, even if they did not extirpate, at least they managed to abate it. Realism can charm us with wit or shrewdness of observation, it can wring our hearts by graphically portraying a moving situation, but it is not poetry, is inimical to poetry, and when the one walks in at the door, the other flies out of the window.

Poetry is like the lily, the most beautiful of all plants, which is not a hot-house flower but does require careful culture and a genial climate. On draughty slopes, in stiff soils, wherever harsh winds or late frosts prevail, it will not thrive, and in the hands of a cultivator who does not love it and understand its needs it is here to-day and gone tomorrow. Just so realism, in more than moderate amount, is destructive of the delicate imagination required for poetry. Unfortunately realism has not been pursued with moderation: it is rather too easy for clever persons to accomplish and much too easy for others, clever or not, to enjoy. "Mother, do not check your child! Making things fall is one of his skills," says some imbecile manual at which I have been glancing; and so the child sits in his cot, fancying his skill, and over the side go the fair and fragile things,

> Desires and Adorations,
> Winged Persuasions and veiled Destinies,
> Splendours and Glooms, and glimmering Incarnations
> Of hopes and fears, and twilight Phantasies;

and it is a bewildered creature that is left to contemplate the wreckage.

At the turn of the century the heavens were still fair for poetry. The force had gone out of Swinburne, but there were Bridges, a poet of a high order within his limits; Francis Thompson, another very highly endowed poet, whose "Mistress of Vision" gives a glimpse of the goddess through a blur of tears; John Davidson, neglected now but worthy of note; the Cockney Muse of Kipling and the more classical and to me preferable singer of Empire, Henry Newbolt; Yeats, who having announced his intention of going to Innisfree duly went and stayed, and Housman, a perfect performer of restricted range but one in whose popularity to-day I see testimony to the prevailing pessimism. There were singers also of lesser calibre, the Byroms, Dyers, Akensides as it were of that epoch, to be known to future ages mostly through anthologies; and lastly there were two eminent novelists who essayed the art of poetry, Thomas Hardy, much superior in his main medium, and George Meredith, whose verses seem to me a tissue of self-conscious artifice. A few years later the poet of the day was John Masefield. But the clouds were gathering fast: there came a memorable month when Swinburne died and Lloyd George introduced his budget, April, 1909. The old age was over and a new one had begun.

Let us give the Devil his due. In this new age certain beneficent lines of progress, already begun, have continued with good results. The emancipation of women has been concluded. The lot of the poor, especially of the very poor, has been greatly improved. Humaner views on crime and punishment prevail. The knowledge of how to prevent and to overcome illness has made many very substantial advances, and in this piece of progress we are lucky to have a share. On the other hand, Man henceforth was to look upon himself more and more as a social animal, less and less as an individual human being and less and less as a repository of the divine spirit. More and more he was to lose the religious feeling of personal responsibility for what he was. Science, some one said, had shut the doors of Hell; but at the same time the gates of Heaven closed with a clang. A pessimistic materialism was to be the prevailing creed. The assault on Nature was to go forward with alarming haste. Scenes known and loved in youth became in a short time unrecognisable. Not a place was safe from the penetration of the motorist. In a little while the aeroplane drowned the songs of birds and the sweet whispers of the wind. Even the countryman fulfilled George Gissing's gloomy prophecy that he would become an engine-driver. The machines grew more and more complicated and demanded a greater and greater number of helots to tend them, who in their turn became bored and discontented as their education improved. The upper classes were robbed of their homes; they lost much of their culture and not a little of their tradition. Terrible wars, waged with a barbarity unknown for centuries, huddled the people together like sheep and left them with many of the habits of sheep. Two Satanic devices, the wireless and the pictures, surely the laziest means of entertainment that have ever been known and the best calculated to dull the imagination and blunt the critical faculty, beguiled men away from sensitive perception and quick response and encouraged unintelligent receptivity. In such a Siberia poetry could have

small chance. Instead, men turned their eyes towards the more glorious past and a retrospective phase of literature set in, history, biography, criticism, scientific and philosophical writing, Alexandrianism in short. Then also came the outstanding growth of realism, the predominant character of this century, drawing its vitality largely from the decay of the previous age and not seldom giving forth an effluvium betraying its origin. There is evidently a taste for literature with this "high" flavour, since so many of our successful writers to-day convey the characteristic whiff. In the theatre too, one notices what long runs are accorded to plays about persons neither admirable in what they do nor interesting nor pleasant in themselves. To pass from one of these performances to a comedy by Wilde is like stepping into the sunshine out of some deep cave, not one where the torch's beam lights up the arched darkness, but one of another kind, where the mass of London Bridge Station is piled above and men store, or used to store, the Gorgonzola cheese below.

A modern poet, inhabiting this new world, does not produce the Muses' honey but matter instead which is so morbid that it reminds one of a trying day in hospital. We must not hope for the sweet-breathing thyme trodden by the white feet of the Nine, but make up our minds to pass glumly along the prim rows of lobelias and begonias or too spruce polyanthuses that still adorn the retreats of the mentally afflicted. (Our local preference for coal is very striking, but on enquiry I find that not all our most intellectual men are in favour of it.) The truth is that modern man is becoming enamoured of abnormalities of mind. Not only does he take an unprecedented delight in works of art that suggest nightmares and hallucinations, but he also discovers a morbid interest in plays, novels and films that deal with neuroses, disorders of conduct and insanity itself. A strange phenomenon, that seems at first sight unaccountable! For three-quarters of a century now this modern man has been busy piling up a prison for himself stone by stone, until at length, oppressed by a feeling of confinement, he has begun to turn a speculative eye towards a cell over the way, where the walls are not papered with rules as are his own, because the occupant is crazy and would not heed them. There, it seems, is one who obeys only the laws of his own being, who has contrived for himself a corner where governmental control does not penetrate and all individuality is not crushed out by the pressure of the herd, one who even escapes those impositions that are so wearisome that, by the device of paraleipsis, I bring them to notice by *not* mentioning them.

In a similar way the neurotic has a fascination, because his peculiarities of conduct are individual and self-pleasing and form no part of a stereotyped good behaviour. All through this period of time the life of man has been beset by a most serious error, namely, that goodness is to be brought about by regulation instead of being allowed to spring up from encouragement of virtue and wisdom. Modern verse, ugly and uncouth as it is, is a result of this pernicious belief, a reaction to it in fact, but an unconscious one.

To present this peculiar matter without unfairness I have limited my choice to excerpts from the Oxford Book of Modern Verse, which contains what is supposed to be the best, and have picked out poets commended by the editor, W. B. Yeats. Sampling is done by opening the book at any place where the chosen poet's work is to be found and putting down a pencil at random. What is forthcoming should then be the best of modern poetry. As a matter of fact the choice of an Irish nationalist to compile an anthology of English verse was a blunder and the book as a whole is not a good one; but the really modern verse is so unlike anything in the normal English character that Yeats' prejudices are not awakened: in fact he seems to like it. I ought to add that I do not count writers in the traditional style, such as Rupert Brook, among the moderns; and Heaven forbid that I should be held to include the fine country-bred Muse of him who delightfully styles himself "The Unteachable"—

> and this, all said and done,
> I like him for; he'll sit by his old tree,
> To eat his bit of dinner, out of the sun—

that is Mr. Edmund Blunden. No, I mean works that the present only could bring forth, unlike those of any other age.

(To be concluded)

Reunion

T. B. LAYTON, Esq., D.S.O., M.S., F.R.C.S. and K. H. DIGBY, Esq., O.B.E., F.R.C.S.

Mr Layton was appointed Surgical Registrar in 1908 and Professor Digby in 1909. This was at a time when there were but two such posts, one being appointed each year and holding office for two years. These two were together therefore from 1909–1910. Mr. Layton's history requires no recapitulation. Professor Digby went out to Hong Kong where he became first, Professor of Anatomy and later Professor of Surgery, was held by the Japanese during their occupation, and has only recently returned to this country, on a visit. Between 1910 and now they have met but twice, once for five minutes in the street and then recently at Guy's, where the photograph on the opposite page was taken. We reproduce it as being of particular interest to Guy's men of the pre-1914–18 War vintage.

Reviews

Cunningham's Manual of Practical Anatomy. By JAMES COUPER BRASH. 11th Edn. Geoffrey Cumberlege. Oxford University Press. *Price* 21*s. each vol.*

Two further volumes of this eleventh edition are now on the market, Volume II dealing with the Thorax and Abdomen, and Volume III with the Head, Neck and Brain. The text has been thoroughly revised, with the aim of making detail, on occasion not in itself of immediate essential value, an element in scenic description as the student finds his way about the body, appreciating the main features of the landscape. No great changes have been made in the method of dissection, except that the brain is now studied from the hind-brain forwards. Neither sales-talk nor commendation is necessary with so wisely and widely accepted a book.

H.A.R.

Medicine. Vol. II. By A. E. CLARK-KENNEDY. Livingstone. *Price* 25*s.*

Dr. Clark-Kennedy, Physician to the London Hospital, Dean of the Medical School and Fellow of Corpus Christi College, Cambridge, is appalled at the number of divisions and sub-divisions into which medical science has become separated. Under this influence, he feels, the medical student may be presented with a series of facts, admittedly classified but nevertheless disjointed. No opportunity thus arises to take the *holistic* view, with which Smuts was so concerned.

This new work by Dr. Clark-Kennedy, of which the book under review represents but the second and concluding number, is intended, therefore, not to provide facts but "to inculcate an attitude of mind." It is devoid of the usual headings and can be regarded as a written record of a physician's thoughts and reflections. At times these are inspired. But, like most people, even a good physician can wander, and the subjects and deductions which then claim his attention can be mediocre or even boring.

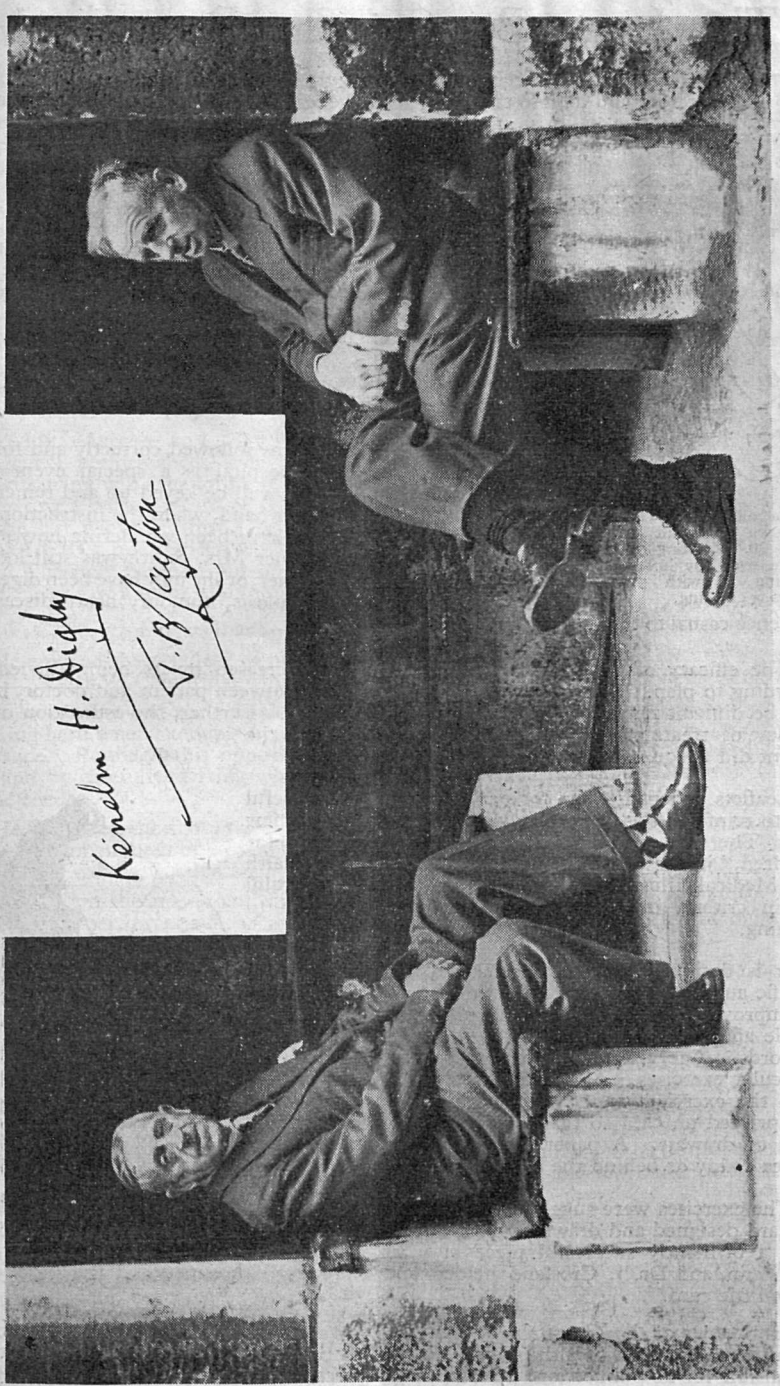
The practising medical man may find this book both stimulating and provoking. The undergraduate, still lost in a forest of lessons and specialties, is in great need of guidance and perspective. Whether, however, he will be given a true sense of direction by Dr. Clark-Kennedy's musings on medical geography is doubtful.

G.

Also received.

Aids to Forensic Medicine and Toxicology. By S. H. RYFFEL. 12th Edn. Bailliere, Tindall & Cox. *Price* 4*s.* 6*d.*

Aids to Tuberculosis Nursing. By L. E. HOUGHTON and T. HOLMES SELLORS. Bailliere, Tindall & Cox. *Price* 5*s.*


Kinahan H. Digby
V. B. Lawton

They Listen, But Can They Remember?

"DON'T worry, Mrs. Perrin, show this to the nurse and she'll take you to the laboratory and then to the X-ray, take the tablets in a little water every evening, and don't eat quite so much starchy food and come up again on a Wednesday morning or Friday afternoon in about 4 weeks' time, good-bye, next patient please."

Blow a balloon up and keep it blown up, while you count 20. Putting your tongue over the hole or pinching it with your fingers is cheating.

Or

"It's nothing serious, Dad, just give Douglas the nose drops, you can get them at the dispensary, and don't forget to have him lying down with his head well back, and I want him to wear a cotton vest and have a Kapok pillow instead of a feather one, and for the feet, get him to practise exercises and . . . and. . . . ?"

For one reason and another it seems worth while to tell patients to do this and take that and avoid something else.

How often are the instructions followed correctly and for the time intended? Coming to hospital is a special event in a person's life, and he or she may well be keyed up and remember better than usual. On the other hand, when the instructions for treatment were given, she may have been wondering how to get to the X-ray department, whether Mrs. Smith was still looking after the other children left with her, or she may have been digesting someone's reference to tuberculosis, tumour, heart disease, a reference casual to the speaker but sinister to the hearer.

The efficacy of treatment will (one hopes) be increased by its being carried out according to plan. Nothing can replace the contact between patient and doctor, but it may be difficult for a patient to remember his advice. Further, the estimation of the efficacy of treatment depends on knowing whether the patient did adequately carry out the plan.

Leaflets and pamphlets for patients can serve a useful part to reinforce the doctors' advice. They are not a new idea. The one on "Special Breathing Exercises for Children," just issued by the Department of Child Health and Medical Illustration at Guy's, is planned to fulfil certain criteria important in the making of an aid to teaching.

It is designed for one special purpose and for one specific audience—to teach children of 6 to 12 years how to improve their expiratory breathing muscles. It is simple and each item is presented in a picture as well as in words. The general principle is stated and then the particular exercises. As the children will be expected to learn the exercises and then continue them for months, it is printed on card so that it can stand by itself on the chest of drawers. A paper leaflet would get put under the tea caddy or behind the clock on the mantelpiece.

Throw a feather up in the air and see how long you can keep it there by blowing.

The exercises were suggested by Dr. P. R. Evans, and the card designed and drawn by Miss Treadgold, who has done a brilliantly successful piece of work. Dr. Crisp, Dr. Mann, and Dr. J. Crosland helped and Dr. MacKeith supervised the production of the little card.

Any reader of the *Gazette* may obtain a copy of this card, free of charge, from the Department of Child Health, Guy's Hospital, S.E.1. Comments are invited by those responsible for its publication. Further supplies can also be obtained from the Department. Price 9*d*. each, 33*s*. for 50, £3 for 100, £25 for 1,000 copies, post free.

Obituary

Dr. EDWARD MORGAN

(Guy's, 1900–1906)

TEDDY MORGAN died on Thursday, September 1st, 1949, at North Walsham, Norfolk, in his 70th year. This brief announcement will bring back many memories to Guy's men of the 1900's. Teddy Morgan has been described as the finest left wing three-quarter who has ever played the Rugby game. Suffice it is to say that he played 16 times for Wales in six years, between 1902 and 1908, and will be best remembered by the general public for the try which he scored against the record-breaking "All Black" side at Cardiff in 1905. By this try Wales beat the "All Blacks" and broke their unbeaten record. The writer had an opportunity of seeing the ball with which this try was scored in a glass case in Teddy Morgan's house in Swansea, during a visit of the Guy's team. It was one of his most treasured possessions.

Many old Guy's men will join in paying tribute to this famous Guy's man, and will extend sincere sympathies to his relatives.

W.D.D.

T.A.C. writes :

Teddy Morgan will long be remembered especially by Guy's men for his "rugger" performances—who ever saw him rounding a full-back or tackling his opposite wing will ever forget it ?—but I had the privilege of being associated with him in creating a cricket record at Guy's. At Honor Oak Park in 1901, he and I put on 155 for the last wicket against Upper Tooting. We neither of us were regular members of the 1st XI ; our respective scores were 73 and 75 both not out, and there were a few byes. The only name of our opponents' team that I can remember is D. H. Butcher, but I never saw a team so disappointed and disgusted.

And F. C. W. reminds us that :—

He enjoyed the privilege of playing Rugby Football with Teddy in his first big match for Guy's against Cambridge University and the memory remains still vividly impressed.

A lovely day and the 'Varsity with their embryo Blues all set for distinction were pressing hard when suddenly a quick movement gave the little schoolboy, as then he was, a chance. Rounding his opposite number, eluding the full back, he streaked for the line and by carefully nursing what room he had, managed to hurl himself over the line in the corner.

He was given the shot at goal and there it went, plumb in the middle right at the top, to the accompaniment of a prolonged round of applause from the undergraduates rattling their sticks on the wooden stand.

Guy's won the match and dined in Trinity. Thus was heralded the advent of an outstanding performer whose name conjures up many other memories of daintiness, grace and good sportsmenship in the arena.

A great player who gave innumerable thrills of pleasure to friend and foe both on and off the field—Teddy Morgan !

Students' Union Book Exchange

The Book Exchange has now been moved from the Students' Union office to the adjacent room in the Old Pathology Block, previously used as a Ladies' Locker Room. All students entering the Hospital in October have been informed of its existence, and it is hoped that there will be a considerable influx of recent and recommended textbooks for them to buy.

This scheme has now been functioning for about two years, and over 2,000 copies have been sold. Books for sale are brought in or sent to the office, the seller stating the price required. After a record has been made, the book is placed on the shelves for sale, the price having been marked on the fly leaf. Purchasers pay the sum demanded and this is credited to the vendor, to be collected when so desired. Money is paid out only when the transaction is completed. A levy of 3d. is made on every book sold for 2s. 6d. or more. Those not disposed of can be withdrawn at any time.

The Book Exchange is open daily from 12.30 to 1.30 p.m.

Correspondence

Student Exchange.

SIR,—We are taking this opportunity to express our appreciation to all those at Guy's who made our stay so pleasant and profitable. Most especially are we indebted to the Dean and to the Students' Union who have been instrumental in making this exchange possible.

It may be of some interest to those with whom we were unable to speak at length that we set down some impressions that we have garnered during our stay. We hope that our statements will be construed as observations and not as judgements.

Perhaps most notable to us was the degree to which the hospital has overcome the obstacles imposed by the war, such as bomb damage and material shortages. All things considered, we believe the similarities far outnumber the differences in medical education in our two countries, and we shall confine our remarks to the latter. In the United States to qualify to practice medicine one must complete three to four years of general education at the university level followed by four years of medical school, consisting of two pre-clinical and two clinical years. At the end of this time the degree of M.D. is conferred. In most states, an additional year of internship, as well as state board examinations, are mandatory for licensure. Thus the clinical training is of essentially the same duration.

The duties of students at the various stages of clinical training are more clearly defined in the British system. In most of our hospitals, the responsibilities delegated to the student are left more to the discretion of his immediate superior and depend less on a formal division of duties.

We benefitted greatly from the close contact with the Registrars, men whose prime responsibility is to the student. In American hospitals, too often, the staff members in comparable positions are charged with additional duties which prevent them from devoting an adequate amount of time to the student.

The fundamental tools of the physician, the history and physical examination, are utilised to a greater degree than in our teaching hospitals, where laboratory and X-ray facilities are more readily available in variety and quantity. A final difference which "even the Americans" cannot match is the distinguished history and tradition which is kept in constant focus, and serves as the foundation for the high quality of medicine taught and practised at Guy's to-day.

It has been a doubly rich experience because in addition to facts and techniques observed and acquired, we have had the advantage of living and working with British people from all walks of life, the patients, the lay and professional staff, the students. All were interested in us, many taking us into their homes and showing us much more of London and the country than we could have possibly seen for ourselves.

We hope that we have played a part in helping to show that a student exchange programme, such as that in which we have participated, is of definite value, and that discussions both medical and of more general topics, in the wards, at table, and in the "Miller" have broadened the perspective of all concerned. We look forward to the perpetuation and growth of this programme in future years.

Again we wish to thank all those who have been so kind to us and trust that the students from Guy's who visited the United States this summer have been as hospitably received, and have had as many profitable experiences as we have had. Anticipating the continuation of the many friendships we have begun, and the expectation of some day returning, might we presume to consider ourselves in some small way, Guy's men ?

Yours, etc.,

WILLIAM E. DEUTSCH,
University of Illinois College of Medicine.

ROBERT T. McSHERRY,
Yale University School of Medicine.

R.M.S. Scythia,
At Sea.

Guilty but Insane.

SIR,—Dr. Keith Simpson's lecture, published in the July 30th edition of the *Gazette*, is distinguished by that clarity, lucidity and objectivity for which he is rightly renowned. It throws into clear relief a question which he does not ask himself, although Dr. Gillispie, to whom he refers, considered it most important. It is whether the jury, without technical training or judgment, can fairly be considered competent to decide the purely medical problem of the diagnosis of insanity. To endeavour to simplify that problem for them by defining an entirely artificial mental state on a legal basis, labelling this legal insanity, and despite the completely ludricrous and obsolete nature of this conception, compelling both laymen and expert witness to confine themselves to it, is simply to confound confusion in the name of common sense.

It would be wiser to acknowledge that the McNaghten rules, formulated over a hundred years ago by judges learned in the law but entirely ignorant of the nature of mental illness, are no more than an arbitrary formulation of a non-existent condition and as such constitute a lamentable basis upon which to administer justice. The fact that very few doctors will be found—and I should certainly not be one of them—to dispute the correctness of the jury's verdict in the case of Rex *v.* Haigh is really beside the point.

Dr. Gillespie's recommendation was that the trial should be undertaken upon the purely factual basis of whether or not the accused person committed the act with which he was charged, while the diagnosis of his state of mind was separately determined by an impartial tribunal of medical experts appointed for this purpose. Their criteria would be those naturally used for the diagnosis of certifiable insanity, and their diagnosis would be accepted by both sides and by the judge, in his disposal of the case. No one would suggest that a jury, no matter how expertly or, as all too often happens, contradictorily advised, were competent to decide whether a particular patient suffered from glandular fever or lymphatic leukæmia, when the differential diagnosis was in doubt; and decisions in psychological medicine are frequently as complicated. Common sense, no matter how hard-headed and practical, is really no substitute for training and experience in any branch of medicine: and there is no getting away from the fact that the mental state of an accused man is a medical and not a legal problem.

Yours, etc.,

Massachusetts General Hospital, Boston. DAVID STAFFORD-CLARK.

The Greensward

SIR,—During the past few days it is obvious that some irresponsible members of the Hospital are using the grass in the Park as a short-cut to their destinations.

The over-taxed turf will scarcely stand up to this further indignity and already there are the easily discernable worn patches of a track between the Nurses' Home and the pathway to Sheppard's House.

I feel sure that these people will at once desist when they realise that they are responsible, not only to the Hospital, but, more important, to the Patients, to keep the Park as pleasant and tidy as possible.

Yours, etc.,

Guy's Hospital, S.E.1. E. J. McGUIRE.

Guy's Diary

September

ACADEMIC

Exhibition. Surgical Department. "Hæmaturia."

12th. 3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

15th. 4.30. X-ray Demonstration. Gordon Museum.

16th. 1.00. Dr. Mann. Clinical Lecture. "Cancer of the Stomach."

19th. 1.00. Mr. Gibberd. Clinical Lecture. "The Attitude of the Fœtus in Utero."

3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

20th. 12.0. Neurological Demonstration. Preclinical Classroom.

22nd. 1.00. Mr. Eckhoff. Clinical Lecture.

4.30. X-ray Demonstration. Gordon Museum.

23rd. 1.00. Dr. McArdle (for Dr. Grant). Clinical Lecture. "Motion Sickness."

24th. 10.0. Surgical Department. Clinico-Pathological Meeting. Anatomy Theatre.

SPORT

17th. Rugby XV. *v.* Catford Bridge. (H.O.P.).

24th. Rugby XV. *v.* Blackheath. (H.O.P.).

Hospital Information, etc.

NOTICES

REPRESENTATION OF REGISTRARS

A letter has been received from the Secretary of the Committee of Registrars of one of the English Hospitals, expressing a desire to contact similar committees in other Hospitals, on the grounds that the conditions of service and the prospects of Registrars were matters that warranted investigation and ventilation on a national basis. At present there is no such organisation in this hospital, and therefore no means of replying. It is intended to leave the matter over until the forthcoming Junior Staff Annual Meeting, but if any Registrar considers the matter of sufficient urgency to merit a meeting of Registrars being called forthwith, would he please communicate with the undersigned.

H. A. RIPMAN,
Guy's Hospital, S.E.1.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

PROPHIT RESEARCH STUDENTSHIP

A candidate will be nominated by the Council of the Royal College of Surgeons of England in October next for a Prophit Studentship in Cancer Research.

The value of the Studentship will be £500 per annum, with an allowance not exceeding £200 for expenses of travelling, and will be for one year, from 1st January, 1950, in the first instance, but renewable annually up to five years at the discretion of the Special Trustees on the nomination of the Council of the College.

Students may be male or female.

Applications, giving a statement of the proposed research and accompanied by a recommendation from a member of the staff of the applicant's Medical School or University, should be sent to the Secretary, Royal College of Surgeons, Lincoln's Inn Fields, W.C.2, before 21st September, 1949.

PASS LIST

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

August, 1949.

Surgery.

*W. G. Burvill-Holmes	*D. J. Joubert
*J. T. Cecil	*J. D. Morris
*M. C. Gilbert	*P. B. Poole

Pathology, Bacteriology and Forensic Medicine.

*J. A. Payne

Medicine.

*A. H. R. Hewett-Clarke	*J. A. Payne
*E. W. Melia	*P. B. Poole

Midwifery.

*A. K. Doust	*E. W. Melia
*M. C. Gilbert	*J. D. Morris

* Have completed the examination.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

Faculty of Dental Surgery.

Mr. W. Kelsey Fry has been re-elected to the Board of the Faculty of Dental Surgery by the Fellows of the Faculty.

Mr. K. E. Pringle has been elected to represent the Licentiates in Dental Surgery of the College.

APPOINTMENT

D. N. Leeming, M.R.C.P., has been appointed Chest Physician, Southport and Ormskirk areas.

CHANGE OF ADDRESSES

B. H. Dicker, L.D.S., R.C.S., Harfields, 63, High Street, Fareham, Hants.

K. H. Hole, Surg.-Capt. R.N., 4, Upper Knollys Terrace, Plymouth, Devon.

PAPERS BY GUY'S MEN

Brock, R. C. Surgery of Pulmonary stenosis. *Brit. Med. J.*, 1949, ii, 399.

Hunt, J. N. The simultaneous estimation of the absorption of water and sulphaguanidine from the stomach of man. *J. Physio.*, 1949, **109**, 134.

Lane, R. E. Care of the Lead Worker. *Brit. J. Indust. Med.*, 1949, **6**, 125.

Law, F. W. The causation and treatment of detachment of the retina. *Practitioner*, 1949, **163**, 187.

Paine, D. T. H., and Another. Salt and Water Depletion in Surgical Practice. *Brit. Med. J.*, 1949,ii, 137.

Parfitt, Gilbert J. The Hypotheses Concerning the Ætiology of Dental Caries. *Proc. Roy. Soc. Med.*, 1949, **42**, 393. (Sect. Odontol.).

Parfitt, G. J. Topical application of solutions of fluorides to the teeth. *Brit. Dent. J.*, 1949, **87**, 53.

Piercey, J. E., and Another. Gleanings in the Field of Thyroid Surgery. *Lancet*, 1949, ii, 141.

Randall, K. J., and Others. Concentration of Diphtheria Antitoxin in Cord Blood and Rate of loss in Babies. *Lancet*, 1949, ii, 324.

Rees, R. J. W., and Robson, J. M. Additive effect of Streptomycin and *p*-Amino-Salicylic Acid in Experimental Tuberculosis Infection. *Nature*, 1949, **164**, 351.

Simpson, Keith. Foul play (abstract of lecture). *West. Lond. Med. J.*, 1949, **54**, 49.

Witts, L. J., and Others. Experimental Macrocytic Anæmia in the Rat Treated with Purified Liver Extract, Pteroyl Glutamic Acid and Vitamin B_{12}. *Nature*, 1949, **164**, 188.

BIRTHS

KINDER.—On August 30th, 1949, at Guy's Hospital, to Audrey (née Debenham), wife of Hugh Kinder, M.A., M.B., B.Ch.—a son (Richard).

WILLCOCK.—On August 21st, 1949, at The City and County Hospital, Londonderry, to Jennifer (née Crosland), wife of R. D. Willcock, M.B., B.S.—a son (Alan Doidge).

MARRIAGES

FORSDICK - SAMOILYS.—On Saturday, August 27th, 1949, at Southwark Cathedral, Dennis H. Forsdick, M.B., B.S., to Helen Eirene Samoilys.

DEATHS

Dr. G. Haslewood wishes to express to his colleagues and friends of the Hospital and Schools his sincere appreciation of the many kind and sympathetic messages which they have sent to him on his recent bereavement.

EDS. {H.A.R. / R.G.}

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

A MAN grown-up, revisiting the spacious gardens of his childhood, finds but a paltry little plot, the mountains he climbed have dwindled to mole hills, and the lakes and rivers that he navigated have become but puddles and trickles. Sixty strides from the porch to the front gate were sixty strides and that's the devil of a way. It seems incredible, almost inconceivable, that his world of yesterday should have become so minute an acre to-day, and could he not see it with his own eyes it would, no matter who assured him, remain the spacious garden with its mountains, lakes and rivers, in his mind. But seeing is believing.

A hundred years ago, England was a big place. It took days to get from a town at one end of it to a town at the other. That makes a place big. Why should it matter in Westminster what they thought in Washington? America was the business of Americans, and an Englishman's business was England, and apart from some measure of endeavour to maintain the balance of power within certain broad and favourable limits, the main concern when a neighbour met trouble was to gather up the profits while the lapse lasted.

"The world is a small place," is an old tag. There's no doubt it's getting smaller. It's shrunk like a sock and it's still shrinking.

Last week, while Sir Stafford Cripps and Mr. Bevin were in Washington, but a short time after our two visitors from the Johns Hopkins had left us, and but a little while before our own two travellers for this year depart for Baltimore, Guy's was visited by a fact finding commission of American Congressmen. A State Medical Scheme is the talk of the day on the other side of the Atlantic. In its wisdom (rather than take the plunge without first filling the bath or learning about swimming), the American Congress decided to find out what it could, of how the scheme was working over here, and dispatched a mixed team of Republicans and Democrats on a heavy programme of investigation in Great Britain. Besides a visit to Mr. Bevan in his ministry, it was arranged that they should be given facilities for seeing two voluntary hospitals, Guy's and King's College. Arriving at 11.30 a.m. and leaving at 2.0 p.m. last Tuesday, they must have found the time all too short, but we sincerely hope that such as it was, their visit was a success.

They were met in the Board Room by Lord Cunliffe, the Superintendent, the Clerk to the Governors, Professor Johnston, and four members of the staff, and given *carte blanche* to ask what questions they liked. They were interested to know how the scheme was affecting the hospital, in its work for the patients, in its administration and in its expenses, and what the impact of the scheme was on the consultant staff, as regards their ability to do their work and their financial reward. Considering the time at their disposal all these problems were thoroughly discussed, fairly, without political bias and from all angles. Lunch was then served in the Nurses' Home, and at small tables questions continued to be asked and answered during a very excellent meal, to which some came late, having been shown round the wards.

Throughout the visit one could not help but be impressed by the harmony, cordiality and frankness which existed between these Americans and our own people. It seemed as though they were visitors, not from another nation, but rather from a nearby county. It seemed as though the Congressmen and the Guy's men who met on that occasion had profited by being colleagues at war, by the exchange of representatives between the Johns Hopkins and ourselves, by a vision of world horizons in their proper perspective. In fact it seemed as if here at least, at last, were world citizens (in spirit, anyway), fully aware of the fact that the porch and the front gate were a lot closer together than they used to be.

Morbid Significance of Modern Verse

By H. St. H. VERTUE.

II.

(Concluded)

"*So far from the position holding true, that great wit (or genius, in our modern way of speaking) has a necessary alliance with insanity, the greatest wits, on the contrary, will ever be found to be the sanest writers.*"—LAMB.

Our first sample runs thus—

You tossed a blanket from your bed,
You lay upon your back, and waited;
You dozed and watched the night revealing
The thousand sordid images
Of which your soul was constituted;
They flickered against the ceiling,
And when all the world came back
And the light crept up between the shutters,
And you heard the sparrows in the gutters,
You had such a vision of the street
As the street hardly understands;
Sitting along the bed's edge, where
You curled the papers from your hair,
Or clasped the yellow soles of feet
In the palms of both soiled hands.

"What voices enrapture the night's balmy prime?" This is the new Apollo. It will be seen that the metre is the ordinary iambic tetrameter often called "octosyllabics," but the stresses are not at all regular. At lines 6 and 7 it is broken, no doubt intentionally, but the effect is ugly; line 15 is imperfect, and lines 11 and 12 can be best made to fit the metre by counting the syllables. At the end of the last mentioned is the very awkward stress on the conjunction "where." There are rhymes here and there, but they are so haphazard that one really does not know whether "waited" and "constituted" are a very ill-matched pair or merely accidentally similar. The matter is not poetic but is the dingy stuff of the realists, beneath the dignity of the lofty Muses. Glance back at them but for a moment, touching a similar theme.

Anon his heart revives: her vespers done,
Of all its wreathed pearls her hair she frees;
Unclasps her warmed jewels one by one;
Loosens her fragrant bodice; by degrees
Her rich attire creeps rustling to her knees. . . .

Can any other civilization show so great a change in the art of poetry in so short a time? After Keats the new matter seems sordid and the form shoddy. Is this the best we can do?

However, there has been material here to criticise, whereas the next example seems sheer vacuity.

Ass-face drank
The asses' milk of the stars. . . .
The milky spirals as they sank
From heaven's saloons and golden bars,
Made a gown
For Columbine,
Spirting down on sands divine
By the asses' hide of the sea
(With each tide braying free).
And the beavers building babel
Beneath each tree's thin beard,
Said, "Is it Cain and Abel
Fighting again we heard?"
It is Ass-face, Ass-face,
Drunk on the milk of the stars
Who will spoil their homes of white lace—
Expelled from the golden bars!

I was once much impressed by the sad fate of a gentleman suffering from schizophrenia, who would scratch away on his violin for a few moments, producing a disordered sequence of notes suggesting some incoherent memory of a tune heard long ago, and would then go back to his favourite avocation of standing on one leg in the corner. The words in these verses have about as much sense as that fiddler's performance and leave exactly the same impression. Beside the lady who wrote them Laura Matilda seems almost a sound performer, and a melodious one, too.

Hark! what soft Eolian numbers
Gem the blushes of the morn!
Break, Amphion, break your slumbers,
Nature's ringlets deck the thorn.

Ha! I hear the strain erratic
Dimly glance from pole to pole;
Raptures sweet and dreams ecstatic
Fire my everlasting soul.

Where is Cupid's crimson motion?
Bellowy ecstasy of woe,
Bear me straight, meandering ocean,
Where the crimson torrents flow.

Lithe and listen, gentlemen. The old Laura sprang from the wit of two sane men, who knew quite well how absurd she was and meant her for a joke. The new Laura, crack-brained Muse of a modern poetess, is taken perfectly seriously and is not meant to sound like a parody. "No insight!" as we should say.

The following is the third specimen.

Can the mole take
A census of the stars?
Our firmament will never
Give him headache.

The man who nuzzles
In a woman's lap
Burrows towards a night
Too deep for puzzles.

While he, whose prayer
Holds up the starry system
In a God's train, sees nothing
Difficult there.

So I, perhaps,
Am neither mole nor mantis;
I see the constellations
But by their gaps.

This piece is read most naturally as prose. However, it is printed as verse and there are rhymes. After bestowing upon it such careful scrutiny as one might upon a microscopic specimen, one may pronounce the opinion that it is a degenerate specimen of the catalectic dactylic metre with frequent anacrusis used by Byron in "When we too parted, In silence and tears," with loss of the excellent contrivance of internal rhymes, of cunningly varied weak caesuras, of deliberate and careful introduction of the spondee, of almost all rhythm, in fact of everything that distinguishes the touch of the master-hand from a mere twangling of the lyre. "Can the mole take a census of the stars?" Does the mole, for that matter, suffer from headache? In the second stanza we are plunged into something Freudian and in the third into some odd theology. The last stanza is connected with the first by the mention of a mole and with the third by the mantis, a "seer," but zoologically a "praying-insect," and in the Freudian stanza there is an idea of darkness in common with the rest. But the author has not integrated his thought; therefore, although you may turn the thing this way and turn it that and cogitate over it as long as you please, the meaning will always elude you. Its broken quality again reminds one of the effusions of the schizophrenic. The poet is sane, but his writing is suggestive of the insane. Of course he could do infinitely better: why does he not?

The author of our next example has achieved such a reputation that his name is known to every one.

The silly fool, the silly fool,
Was sillier in school
But beat the bully as a rule.

The youngest son, the youngest son
Was certainly no wise one,
Yet could surprise one.

Or rather, or rather
To be posh, we gather,
One should have no father.

Simple to prove
That deeds indeed
In life succeed
But love in love
And tales in tales
Where no one fails.

"Every word, phrase, sentence and paragraph must move in a logical progression and convey a definite conventional import," is the injunction of Stevenson; but it is not followed here. Indeed, that first necessity of putting words together, that in the result they should *mean* something, has not been felt. We are invited to admire, but not to understand. Certain sorts of persons will do this, but I forbear to give a name to them.

One resource is left to us: we may study the last piece in the book and thus learn the quality of the very latest poetic art. It begins thus:—

He comes along
The summer throngs of the young
Rose, and in his long
Hands, flowers, fingers carries;
Dreamed of like aviaries
In which phœnixes sing,
Promising touch soon
In summer, never to come.

It is unnecessary to finish the verses: one speaks for all.

We have been admitted to a world of which a normal man only gets a glimpse when he suffers from high fever or has a bad pain. Under these circumstances logical thinking is suspended and its place is taken by pictures, which are often grotesque, come unbidden and are seemingly unconnected one with another. They are not at the time subjected to analysis, they seem to take command of the mind and if in the extreme the sufferer mistakes them for reality, he is delirious. In a similar way arises the tousled, incoherent imagery of the modern poets. They think like a sick man in pictures. The poets of the past on the other hand, though they too were equipped with the power of pictorial thinking, never lost grip on their thought, had command of their imagery and retained their critical and analytic faculties. Their pictures may surpass those of any painter for the simple reason that they are not static.

My soul is an enchanted boat,
Which, like a sleeping swan, doth float
Upon the silver waves of thy sweet singing;
And thine doth like an angel sit
Beside a helm conducting it,
Whilst all the winds with melody are ringing.
I seem to float ever, for ever,
Upon that many-winding river,
Between mountains, woods, abysses,
A paradise of wildernesses!

Here, as any one may see, the imagery is not only beautiful in itself but it displays also a perfect certainty in the choice and is throughout pellucidly clear; but in the modern

verses the most superficial association seems to suggest some of the material, or even mere assonance. Cain, for instance, would not be fighting Abel if it had not been for the Tower of Babel, and the beavers only have homes of white *lace* on account of "Ass-*face*." But even the white lace must have associations in the poet's mind other than those of sound, and there is not much doubt that between these moles and beavers and long-fingered persons associations lie with buried material, which is thus brought up to the surface in disguised form. Preoccupied so with repressed matter the poet discourses in a language incomprehensible to every one, himself included. He has no longer need for clarity, is not concerned with form, cares not for coherence, allows his images to tumble out just as they come—" and in his long hands, flowers, fingers carries "—and brokenly and uncouthly jangles the lyre as the schizophrenic scraped his fiddle. The art of poetry breaks up in his hands and he is content. Unreality pervades his work, the time-honoured distinction between insanity and genius. Nevertheless the modern poet has not lost his sanity altogether; his personality has undergone division; one part retains contact with daily life and the other part, represented by his Muse, has gone mad. Thus he escapes from a world intolerable to him—but at what a cost! His gifts are valueless, his poetry is debauched, and we who ask for bread get nothing but chaff.

In the past, when the poets have suffered, they have not exercised this ingenuity. How should they, loving and honouring the Muse? There was a time between Pope and Wordsworth of utilitarian philosophies, of unbounded faith in the reasoning faculty and of the supremacy of prose, that brought forth Adam Smith's "Wealth of Nations," Blackstone's "Commentaries on the Laws of England," Gibbon's "Decline and Fall," and the historical and philosophical treatises of David Hume, that saw Dr. Samuel Johnson ascend the intellectual throne, a time when several of the "poets" were in reality orators writing in verse, such as Young of the "Night Thoughts," Blair of "The Grave," and Churchill the satirist. The true poets were uncertain in aim, frustrated in performance and very uncomfortable in mind. Collins' career closed abruptly in insanity. Gray was a shy recluse, with an exiguous output, nearly a third of which (English and Latin) was unfinished. Cowper led a retired life, suffering from fits of melancholia. Chatterton committed suicide. Christopher Smart was confined in Bedlam; and whether Blake was sane or not is a question difficult to answer. Goldsmith, more at home in the times, preserved his mental balance but undoubtedly felt the effect of this spiritual East wind.

> And thou, sweet poetry! thou loveliest maid,
> Still first to fly when sensual joys invade,
> Unfit in these degenerate times of shame
> To catch the heart, or strike for honest fame—
> Dear charming nymph, neglected and decried,
> My shame in crowds, my solitary pride—
> Thou source of all my bliss, and all my woe,
> That found'st me poor at first and keep'st me so—
> Thou guide by which the nobler arts excel,
> Thou nurse of every virtue—fare thee well.

Dear charming nymph! Even though she was tricked out like Belinda at her toilet, she was still adored. Nowadays the poor Muse like Hagar is banished to the desert, or like the scapegoat driven forth to die, or like Mamurius Veturius beaten out of the city with rods into the enemy's land. The barrenness of the Age of Reason the poets could face, perish though they might in the wilderness, but the Age of Social Man and of Regulation is too forbidding, and from that bleak prospect they shrink away, leaving the Muse to carry their burden and sink beneath it. Shut in their own worlds they babble to themselves and to each other, and oh! how dreary is the sound of it! I cannot convey to you that want of urbanity, cheerfulness, right thinking and fine feeling: you must read them for yourself to sound the depth of their tedious egotism.

The classics, which they have either repudiated or never had, would restore their sense of form, do away with their extraordinary vagueness and rid their minds of the idea that an author's thwarted feelings are of interest to any one except himself. Yet medicament even more penetrating than this valuable corrective is needed.

From the search for that deeper remedy we might shrink back, abashed by the shining splendour of poetry: yet we must call upon our faith to aid us, unrepressed. Surely the poet must grasp the forgotten truth that our subsistence depends upon Nature, without whom we are nought. It is our duty to woo her, love her and under-

stand her well. This is the foundation of planetary life: all else is a superstructure, now grown so vast that at any moment the whole dangerous, top-heavy mass may come crashing to the ground. It will be best to let a poet speak for the poets.

Ah! I know
How ill you are. You shall tomorrow do
What I now order you.
At early dawn through London you must go
Until you come where long black hedges grow,

With pink buds pearled and here and there a tree
And gates and stiles; and watch good country folk;
And scent the spicy smoke
Of withered weeds that burn where gardens be;
And in a ditch perhaps a primrose see.

The rooks shall stalk the plough, larks mount the skies,
Blackbirds and speckled thrushes sing aloud,
Hid in the warm white cloud
Mantling the thorn, and far away shall rise
The milky low of cows and farmyard cries.

From windy heavens the climbing sun shall shine,
And February greet you like a maid
In russet-cloak arrayed;
And you shall take her for your mistress fine,
And pluck a crocus for her valentine.

These fine verses from John Davidson's "Fleet Street Eclogues" are even more true and more moving now than when they were delivered over fifty years ago.

Field and farm are like the temple steps: it is in the adyta beyond that the goddess most fully reveals herself. "Two Voices are there; one is of the sea, one of the mountains"; but a third speaks from the tall trees that of old compassed us always about. There a man may, if he please, wind his arms about some shapely stem, caress a rugged bole or lay his lips to some smooth, white trunk and hold communion with the goddess, while the sunlit foliage above, answering, whispers down. He may kneel by a gushing spring; hearken entranced by a running stream; worship by a still, silent pool, just as his ancestors have done for more centuries than the wisest man can tell. Let it not be forgotten that in the beginning poetry and religion were one. He that would be a full man and a whole man must stand before the mercy-seat in some old church, hallowed by the worship of the pious generations, and feel at one with those that are and those that have passed away, like the great poet of Epicureanism, who bade us banish every harmful thought and every injurious imputation on the godhead, approach the shrine with a calm breast and into a mind at peace receive the images of divine beauty.

Thus is born an ancient wisdom, alien from the world of to-day. So much the worse for that world! It should have been the poet's high privilege to lead us to the light; but since he is baffled, there is nothing for it but to go back to the past for a renewal of our faith. All the same his affliction has not been in vain, for it makest plain the need for grasping tenaciously everything that is good in life.

MUSIS AMICUS.

I love the Muses: bear away,
Ye wanton winds, to seas afar
My glooms and fears; shine, Northern Star—
But on what tyrant's dreaded sway

In icy realms or why there quakes
A Shah, I know not, care not, I.
Clear are the springs and bright the sky
Where the sweet Muse her pleasure takes.

Weave, weave of sunlit blooms a crown
For Lamia's brow, beloved Maid.
Such strain beseems the Sisters' aid;
Without thee nought is my renown.

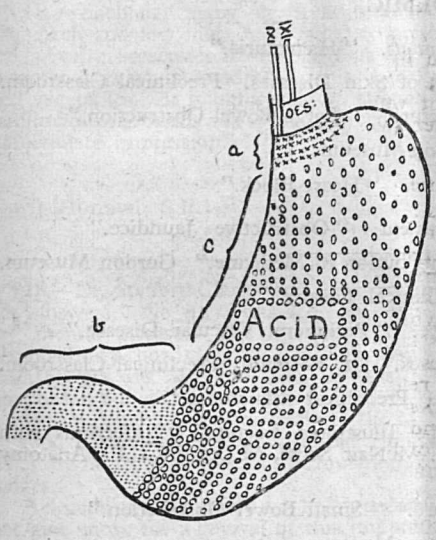
Hor. Od. I, xxvi.

Lectures in Brief—IV.

ACID AND ULCERS

By Sir HENEAGE OGILVIE.

THE stomach is a reservoir into which food is taken in some haste, to be passed on to the lower alimentary tract at leisure. While retained it undergoes softening and partial digestion, as a result of the churning movements and secretions which this organ furnishes. The movements may be analysed as functions (1) of the fundus which like a hopper continually feeds the body with material, (2) of the body, which by peristalsis mixes the food and eventually propels it through the pylorus, and (3) of the pylorus which, by relaxation, intermittently allows food into the duodenum. (The pylorus is probably seldom tightly closed, but the intermittent stimulus of unneutralised acid in the duodenum, or the more prolonged irritation of a duodenal ulcer, may cause it to be so).



The secretions of the stomach are of three types, originating in different areas (see diagram). The secretion of the cardiac glands (*a*) is alkaline, while the pyloric glands (*b*) secrete an alkaline *muscus* also. The *principal glands* (*c*), which densely populate the body, and more sparcely, the fundus, secrete acid and pepsin. It is this latter secretion which has been so thoroughly incriminated by investigations into the ætiology of peptic ulcers. The control of acid secretion is partly neural and partly hormonal. The vagus nerve produces the psychic secretion with which the food is greeted on its arrival in the stomach. (It is this form of secretion which, as shown by Wolf and Wolff's observations on Tom, is so closely associated with changes in motility and vascularity, varying with the mental and emotional state). When the meal is under way, the products of digestion cause a secretory hormone, gastrin, to be liberated from the pyloric antrum, which stimulates a further production of acid, and a similar stimulus is repeated when the food passes on through the small bowel. Fat in the duodenum, has by a hormonal mechanism, an inhibitory effect.

Whatever the causes of acute ulceration (whether neurogenic, infective, toxic or nutritional, and they may be legion, as are the causes of spots on the skin), it would appear to be the presence of excess unneutralised acid, which, if it does not cause, at least predisposes to the establishment of chronicity. The acute ulcers are commonly multiple, punched-out circular lesions, confined to the mucous membrane, and with little surrounding tissue reaction. Most of them heal leaving no trace. They have little tendency to perforation, and if they do deepen, commonly produce hæmorrhage.

Chronic ulcers arise in close relation to the sites at which there is a high acid concentration, namely, in the stomach (predominantly along the lesser curvature, probably because the resistance of this part is lowered by its limited mobility), in the duodenum, in the œsophagus, and after gastro-intestinal anastomosis, in the artificially proximated bowel. On this account all recent attempts to cure chronic peptic ulceration by surgery have been directed at reducing acid secretion.

From the foregoing it is clear that this may be done by removing the neurogenic stimulus (by vagotomy), by removing the hormonal stimulus (by excision of the antrum), or by removing the acid secreting portion, namely, almost total gastrectomy. This last operation has the advantage that without added procedure, it removes the antrum

and sections the major part of the vagus nerves at the same time. If vagotomy is performed an abdominal approach is recommended. This offers the obvious advantage of enabling the lesion to be examined, and section of the nerves need be no lower than in the supra-diaphragmatic operation, because by traction on the cardia, the thoracic portions of the vagus can be brought down into the abdomen. (This operation also interrupts the afferent pathways for pain, which may be considered either an advantage or a disadvantage).

Removal of the ulcer-bearing area clearly has little in theory to recommend it, and in practice is commonly followed by a recurrence elsewhere.

H.A.R.

Guy's Diary

ACADEMIC

Sept.		Exhibition. Surgical Department. "Hæmaturia."
26th.	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
27th.	1.00.	Mr. Blackburn. Clinical Lecture. "Large Bowel Obstruction."
29th.	4.30.	X-ray Demonstration. Gordon Museum.
30th.	1.00.	Dr. Kauntze. Clinical Lecture. "Heart Block."
Oct.		Exhibition. Surgical Department. "Obstructive Jaundice."
3rd.		Exhibition. "Addison's Contribution to Medicine." Gordon Museum.
	12.00.	Surgical Staff Conference. Clinical Theatre.
	1.00.	Mr. Atkins. Clinical Lecture. "Peripheral Vascular Disease."
	3.30.	Demonstration of Skin Diseases. Dr. Forman. Preclinical Classroom.
4th.	12.00.	Neurological Demonstration. Preclinical Classroom.
6th.	11.00.	Department of Child Health. Illustrated Lecture. "Infections with the Herpes Virus." T. F. McNair Scott, M.D., F.R.C.P., Anatomy Theatre.
	1.00.	Mr. Lawrie. Clinical Lecture. "Small Bowel Obstruction."
	4.30.	X-ray Demonstration. Gordon Museum.
7th.	1.00.	Dr. Boland. Clinical Lecture.
	2.15.	Combined Round. Preclinical Classroom.
8th.	10.00.	Mr. Dennis Browne, Gt. Ormond Street Hospital for Sick Children. Surgical Departmental Round. Clinical Theatre.
10th.	1.00.	Mr. Marston. Clinical Lecture. "Anæsthesia in the Dental Chair."
	3.30.	Demonstration of Skin Diseases. Dr. Forman. Preclinical Classroom.

OTHER ENGAGEMENTS

Sept.		
25th.	10.45.	Harvest Thanksgiving Service. Hospital Chapel.
Oct.		
1st.		Rugby XV. *v.* United Services, Portsmouth. (Portsmouth).
		Association XI. *v* Martin's Bank (H.O.P.)
8th.		Rugby XV. *v.* Aberavon. (H.O.P.).
		Association XI. *v.* West Wickham (H.O.P.)

Correspondence

Teddy Morgan

SIR,—The death of Teddy Morgan at the relatively early age of 69 will come as a great shock to many of his contemporaries at Guy's. He had a perfect physique—to which was added a great charm of manner and a complete absence of "side." The description that he was the finest left wing threequarter who ever played the Rugby game will be disputed by few. With O'Brien, McEvedy and Alcock he was one of the best threequarter line Guy's ever had—indeed, it was one of the finest in the country.

Yours, etc.,

B. HALLEY STEWART.

Fairlight,
Totteridge, N.20.

The Memorial Gates

SIR,—Each day many of the hospital staff pass under the 1914–19 War Memorial Arch and few must have failed to notice the objectionable pile of garbage which usually desecrates its base. This has been especially true during the recent hot summer days when hundreds of flies have sported themselves among the rotting food and vegetables. It is unfortunate that such a state of affairs exists on both ethical and public health grounds and it must surely leave visitors to the hospital with nothing but an unfortunate impression.

Yours, etc.,

JOHN DICK.

Guy's Hospital, S.E.1.

Guilty but Insane

SIR—Dr. Stafford Clark seems to have misinterpreted the whole spirit of the McNaghten answers. No jury, unaided, has ever been required to decide the diagnosis of mental disease. The essence of the answers is the determination of criminal responsibility, not insanity. Did this man know what he was doing, and did he know that this act was wrong? The jury has to answer such questions of fact, not give its opinion on a medical condition.

It is becoming the mode to decry the McNaghten answers. I submit that they form as good a guide as ever in deciding criminal responsibility in cases of mental disease. They are far from an arbitrary formulation, being the considered opinion of Her Majesty's judges.

A decade or so ago there was an outcry against "trial by Harley Street" and we should not give cause for a revival of this imputation. The mental state of the prisoner has always been considered in connection with sentence and the Criminal Justice Act, 1948, gives ample provision for extensions of this consideration.

Training and experience in any branch of medicine is no substitute for common sense, and for this the public looks to the jury system, which has stood the test of centuries.

Yours, etc.,

GAVIN THURSTON.

Elderfield,
Hutton Mount,
Essex.

SIR,—I have been interested in the recent correspondence entitled Guilty but Insane. Dr. Stafford-Clark, in the September 10th edition, claims that responsibility for such decisions should rest on psychiatric opinions of the accused's mental state at the time of the crime—his criterion being certifiable insanity.

It is interesting to analyse this more closely. A textbook states that a person should be certified if he—

(1) is liable to injure himself or others, or is unmanageable;

(2) is considered in need of mental treatment such as can only be given at a mental hospital, when the patient is incapable of making such a decision to accept treatment.

(3) In assessing 1 and 2 weight should be given to social and economic factors.

If these are the criterea on which Guilty but Insane decisions should be made—then all murderers by their very act satisfy them.

At what stage in a mental illness can a patient be judged insane ?

I feel Dr. Stafford-Clark has avoided the real criterion for judgment, and that is : " Was the accused responsible at the time the crime was committed ? "

The psychiatrist should certainly be given due weight in his assessment of the prisoner. The legal profession has studied this problem for many centuries and has established a reputation for justice. Thoughts for the safeguarding of the public should also contribute to the decision.

I feel the problem is neither purely medical or purely legal, but one for the widest philosophical judgment.

Yours, etc.,

G. I. TEWFIK.

Lady Chichester Hospital,
Hove.

" Guy's Science Club "

SIR,—I shall be most grateful if you will allow me, through your columns, to give advance notice of the proposed activities of the Guy's Science Club during the coming term. The first meeting will be on Wednesday, 12th October, when the speaker will be Dr. A. F. Hughes, from the Strangeways Research Laboratory, Cambridge. Dr. Hughes, who is well-known to many of your readers, will discuss the applications of cinephotography in biological research and has promised to demonstrate some of his latest films taken with the phase-contrast and polarising microscopes. This subject is of such general interest that it is hoped that as many members of the Hospital and Schools' Staff as possible will make a special effort to be present.

At the second meeting, on November 9th, Professor R. H. S. Thompson will be the speaker, his subject being " The cholinesterases of mammalian tissue," and at the third meeting on December 14th, Dr. H. E. Holling will discuss " Compensatory mechanisms to anoxia."

Meetings are held, informally, at 4.45 p.m. in the Staff Common Room, and are preceded by tea at 4.30. All Visiting, Teaching and Research Staff of Hospitals and Schools are automatically members of the Club, and newcomers to the Staffs will be welcomed. Detailed notices of the meetings will appear in the Staff Common Room, the College and the *Gazette* (Guy's Diary).

Yours, etc.,

C. B. ALLSOPP,
Honorary Secretary, Guy's Science Club.

Physics Department,
Guy's Medical School, S.E.1.

Books and Periodicals—Students' Club.

SIR,—The Committee of the Students' Club is organising a reference library which will be kept in the new Reading Room. It will not be possible to allow the books to be taken away and in order to make them easily available they will be kept on open bookshelves where the risk that they will disappear is obviously a real one. To save unnecessary expense, only a few books will be bought at present and these will be left on the tables in the room.

May I appeal to your readers to see as far as possible that these books are well looked after because the sucess of the scheme will depend on their survival and will decide whether any more can be bought.

There has also recently been an increase in the number of periodicals in the Reading Room. Covers for these have been bought so that old copies are now in good condition. If there is a demand for them it is intended to sell these old copies, the money being credited to the Students' Club.

Anyone wishing to buy a supply of any periodical for the period 8th October to 9th April should make their offer by October 7th to the Students' Union Book Exchange, through which this scheme will be arranged. The periodicals may then be collected

the week after they fall out of date. All copies not sold on this basis will be offered singly at a reduced price.

Complete lists of the periodicals available are published on the Students' Union notice board.

Yours, etc.,

T. M. L. PRICE,
Honorary Secretary Students' Club.

Guy's Hospital, S.E.1.

The Old Guy's

SIR,—I take pen in hand to record my recollections of my entry as a junior clerk under the late Chas. H. Wells, who was at that time Clerk to the Dean under the then Dean, Dr. E. C. Perry, afterwards known as Sir Cooper Perry who followed the late Sir Frederick Taylor and Sir W. Hale White. At that time Dr. Steele was the Superintendent of Guy's Hospital with the late Samuel Prior as the Steward of the Hospital. I joined the staff of the Medical School on August 22nd, 1888, the year following the Jubilee of the late Queen Victoria.

Thomas Morley also was the Janitor of the Medical School, and Peter Mills the Librarian who had held a similar post in the Army before that. A year after, viz. in 1889, the Dental School was started, Mr. M. F. Hopson being the first Dental Student.

My mind often carries me back to my early days at Guy's and it does not seem possible that it is nearly 61 years ago. Please pardon my senile wanderings, I often find myself reflecting on my Medical School experiences. With warm regards,

Yours, etc.,

S. H. CROUCHER.

11 Thornsett Road,
Anerley, S.E.20.

Birth

The sweetened country cannot sing
Before the grace be shed.
Yet, before the snows are fled
And drowsy stream shall move within its bed,
Larch and pine-trees glimmer on the ling.

The early sickle moon is sharp
Contained within the old;
As the shepherd in the fold
Can see slight day on earth as phantom gold,
The morning star above the shrouded park.

The precious structure of the earth
Begins the fruitful song.
Then, before much time has gone
The naked woods their garments bring along:
Shadows of the tender splendour at their birth.

J.C.D.

Reviews

Surgery for Nurses. By JAMES KEMBLE. John Wright & Sons. *Price* 21*s.*

Student nurses will find this a useful and interesting book. The illustrations are excellent and to a certain extent make up for the rather brief accounts of the conditions mentioned. Most nurses would appreciate a little more detail and explanation and would therefore have welcomed a book of this size and quality dealing with general surgery only. To include diseases of the eye, ear, nose, throat, orthopædic conditions and gynæcological conditions, only a brief outline is possible. It is a pity that the obsolete classification of burns is the only one given and surely ether soap and a brush are rarely used now for cleansing a burn. The book is well produced, generously illustrated, and should appeal to student nurses.

F.T.

Textbook of Surgery. By PATRICK KIELY. H. K. Lewis. *Price* 45*s.*

This excellently printed work comes as a further addition to the numerous textbooks of Surgery. It is regrettable that so much of it does not agree with current teaching.

I do not recommend this book to students of this hospital about to purchase a textbook of Surgery.

A.J.D.

Bedside Diagnosis. By CHARLES MACKEY SEWARD. E. & S. Livingstone. *Price* 17*s.* 6*d.*

This small book, which is of the size of *Hutchinson and Hunter*, approaches the problem of Diagnosis from the analysis of certain main symptoms. These form the chapter-headings, of which there are twenty-two, beginning with psychogenic symptoms and continuing through pain in various locations, and such common symptoms as anæmia and dyspnœa, finally to pyrexia. Each chapter begins with an ætiological classification of the causes of the symptom considered, and goes on to examine each cause in the degree of detail which its frequency deserves.

Though it in no way replaces *Hutchinson and Hunter* as the standard handbook for students in the Medical Wards, it is very strongly recommended to them as an additional book to read through in their first three months. It must also be of use to those who, shortly before an examination, wish to remind themselves of the causes of main symptoms.

W.D.B.

Pathology of the Nervous System. By J. HENRY BIGGART. 2nd Edn. Livingstone. *Price* 21*s.*

This book was first published in 1936. It is derived from the series of lectures by the author prepared both for undergraduates and for those taking higher examinations. It is easy to read, excellently illustrated and published with the skill one would expect from Livingstone's of Edinburgh.

Though somewhat more detailed than is required in a book for any qualifying examination, it should certainly be read during the three months of the Neurological appointment, for it will enable the first-class clinical teaching to be set on a firm basis of reliable neuropathology. It can also be strongly recommended to those reading for the M.R.C.P., if they have sufficient time to include amongst their books, one which gives more information than is required in that examination.

W.D.B.

A Textbook of Medicine for Nurses. By E. NOBLE CHAMBERLAIN. 5th Edn. Geoffrey Cumberledge. Oxford University Press. *Price* 21*s.*

This textbook has for many years been used by nurses who want a short account of the common medical conditions. Coloured plates and line drawings are clear and enhance the value of the short written descriptions. The summary at the end of the book is useful for revision.

Under the heading of therapeutics, " too broad a meaning to be an accurate title for this chapter," no mention is made of occupational or recreational therapy; general nursing care, massage and exercise and the use of drugs are included. Diet is mentioned in connection with the particular disease and there is also a chapter on the principles of diatetics.

D.L.H.

Diseases of Women. By TEN TEACHERS. 8th Edn. Edward Arnold. *Price* 25*s.*

The new edition of this standard textbook on Gynæcology has been long awaited. It does not disappoint. Fanaticism in any direction is conspicuously absent, and the subject is made as simple as possible to understand. If any part of the book is due for criticism, possibly it is the chapter dealing with the physiology of menstruation. (On the other hand, this might be pardoned as an honest admission of ignorance). In general, space has been allotted to subject matter in accordance with its importance, and the exposition is abundantly clear. The penultimate chapter on operations will give the student adequate information for him to understand what is being done in the theatre and the final chapter on contraception should be most helpful to the future G.P.

H.A.R.

Sport

RUGBY FOOTBALL

Guy's *v.* Catford Bridge

17th September, 1949.
At H.O.P. Won 11—3.

Guy's opened the season with an unconvincing win over Catford Bridge. The game was scrappy and slow, with few attacking movements. Throughout the game the forwards had more of the ball in the tight. This was due to fine hooking by J. H. Keeling backed by a cohesive scrum. The backs lacked speed in attack and were unable to penetrate the good defence of their opponents.

The first score came late in the first half following a quick heel from a line-out. The ball passed rapidly down the backs and B. M. Gray rounded his man to score. This was converted by G. A. Lawrence. After this, Guy's nearly scored on several occasions and played better football. J. Hobbs rounded off a forward passing movement to score in the corner. The kick was missed.

The second half was much the same. Several opportunities of scoring were missed due to careless play and Catford Bridge gained a penalty goal. Guy's produced one good threequarter movement which resulted in an unconverted try for Gray.

Criticisms of a first game are not usually profitable but the general points arising were that the team as a whole is not yet fit and are not quick enough in attack.

SAILING

Burnham Week

A record entry of 160 yachts, a warm sun, and a fresh breeze combined to turn the usually rather drab River Crouch into a lively spectacle during Burnham Week.

The week opened for the United Hospitals Sailing Club with a race for the Harvey Wright Gold Fruit Bowl, open to the seven leading hospitals in the points competition. The Bowl was won by Middlesex Hospital, Guy's were second.

During the week's racing, Guy's helmsmen or crew were in four winning boats.

In the Sharpie class the Commodore, Sir Heneage Ogilvie was a consistent second in *Maid of Athens*. Ronald Harper raced his newly acquired *Omega* in this class.

The week-end following Burnham Week saw the London Corinthian Sailing Club at Burnham. The occasion was a team race against U.H.S.C. for a Challenge Cup presented by London Corinthian.

Racing was held on Sunday, September 11th, in a strong reefing breeze; in the morning U.H.S.C. were 1st, 2nd and 3rd; in the afternoon 1st, 2nd and 4th. The final score in points was U.H.S.C. 29½, L.C.S.C. 12.

ASSOCIATION FOOTBALL

1st XI. FIXTURES, 1949–50

1949.			
Sept.	17.	Martin's Bank (Friendly) ..	Home
,,	21.	Hospital Trial	Home
,,	24.	Kew Association (League) ..	Away
Oct.	1.	Martin's Bank (Friendly) ..	Home
,,	8.	West Wickham (League) ..	Home
,,	12.	Hospital Trial	Home
,,	15.	Ibis (League)	Away
,,	19.	United Hospitals Trial ..	Home
,,	22.	Great Western Railway (1st A.F.A. Senior Cup) ..	Home
,,	26.	Other Hospitals XI.	Home
,,	29.	Alleyn Old Boys (League) ..	Home
Nov.	2.	Westminster Hospital (Friendly)	Home
,,	5.	Bank of England (League) ..	Home
,,	12.	1st Round Univ. of London Cup *v.* University College ..	Home
,,	19.	Old Latymerians (League) ..	Home
,,	26.	Hendon Police College (Friendly)	Away
,,	28.	Birmingham Univ. (Friendly)..	Home
,,	30.	Normandy Comp. (Friendly)..	Away
Dec.	3.	2nd Round Univ. of London Cup	
,,	10.	Bank of England (League) ..	Away
,,	17.	Old Lyonians (League) ..	Away
1950.			
Jan.	14.	Alleyn Old Boys (League) ..	Away
,,	18.	Royal Marines, Chatham (Friendly)	Away
,,	21.	Old Stationers (League) ..	Home
,,	28.	Old Lyonians (League) ..	Home
Feb.	1.	Southampton Univ. (Friendly)	Away
,,	4.	West Wickham (League) ..	Away
,,	11.	Aquarius (League)	Away
,,	18.	Cuaco (League)..	Home
,,	25.	Cuaco (League)..	Away
Mar.	1.	Northampton Eng. Col. (Friendly)	Away
,,	4.	Irving Sports Strollers (Friendly	Home
,,	8.	2nd Round of Hospitals Cup.	
,,	11.	Kew Association (League) ..	Home
,,	15.	Semi-Final Hospitals Cup: London or Charing X. ..	Home
,,	18.	Northampton Eng. Col. (Friendly)	Home
,,	22.	Goldsmiths College (Friendly)	Home
,,	25.	Ibis (League)	Home
,,	29.	Final Hospitals Cup.	
April	1.	Old Latymerians (League) ..	Away
,,	15.	Aquarius (League)	Home
,,	29.	Old Stationers (League) ..	Away

SKETCH CLUB

It is hoped to form an informal Sketch Club at Guy's in which anyone who is connected with the Hospital may take part. Meetings will probably be monthly and consist of informal discussions and occasional lectures. In order to discuss this with anyone who may be interested, it is proposed to call two meetings on October 5th, at 5.15 p.m. and 9.30 p.m., in the Surgical Exhibition Room, on the first floor, Guy's House. It is hoped that everyone interested will attend one of these.

Hospital Information, etc.

NOTICES

SURGICAL DEPARTMENT LIBRARY

The June, 1949, number of the Annals of the Royal College of Surgeons, Volume 4, No. 6, is missing from the Surgical Department Library. Would the borrower please return this copy as soon as possible.

RESIDENT ANÆSTHETIST

Applications are invited for the post of **Resident Anæsthetist** (B.2); duties to commence as soon as possible. Applicants must have held twelve months' House Appointments. Salary at the rate of £450 per annum, less £100 per annum for board and lodging. The post will be tenable for six months in the first instance. Applications should be lodged with the Superintendent not later than October 3rd.

RESIDENT MEDICAL OFFICER, NUFFIELD HOUSE

Applications are invited for the post of **Resident Medical Officer** in Nuffield House, duties to commence on November 1st. The appointment will be tenable for six months in the first instance and is graded as "Junior Hospital Medical Officer," *i.e.* salary will be at the rate of £700 per annum for an officer appointed not less than two years after registration, less £100 per annum for board and lodging.

Applications, six copies, accompanied by three testimonials, should be sent to the Superintendent on or before October 15th.

HARVEST THANKSGIVING

The Harvest Thanksgiving Service this year will be held in the Hospital Chapel on Sunday, September 25th, at 10.45 a.m. The preacher will be the Revd. A. G. Lough, A.K.C., B.D., of Kingston-on-Thames Parish Church. The music will be led by a special choir from Guy's.

The Chaplain would be most grateful for gifts and offerings in kind for the Service. These should be sent to the Chapel not later than 11 a.m. on Saturday, September 24th.

W. DENYS GIDDEY,
Resident Chaplain.

ST. LUKE'S DAY SERVICE

A special service for doctors, nurses and all engaged in hospital or public health work, will be held in Southwark Cathedral on St. Luke's Day, **Tuesday, October 18th, at 1.15 p.m.** (ending before 2 p.m.). The address will be given by the Revd. Canon Marcus Knight, B.D., Precentor of St. Paul's Cathedral.

It is fitting that such a service should be held on this day, as St. Luke is described in the New Testament as the "beloved physician."

Medical, nursing and other representatives from hospitals and health services in this part of South London are being invited to attend. We trust that it will be fully supported and attended by all past and present members from every department of Guy's.

H. E. ASHDOWN,
Provost of Southwark.

PASS LIST

CONJOINT BOARD

September, 1949.

Chemistry.

F. W. Antscherl — S. A. Lewis
A. L. Benson — W. Strupp

Physics.

F. W. Antscherl — P. Davies
M. F. A. Baker — S. C. Jack
R. B. A. Barr — S. A. Lewis
A. W. G. Cartwright — M. A. Webber
J. C. Cranfield

Elementary Biology.

A. W. G. Cartwright — P. A. McGuckin
S. C. Jack — F. L. Richards

ROYAL COLLEGE OF SURGEONS OF ENGLAND

HUNTERIAN LECTURE.

J. A. Piercy, F.R.C.S. Ed., will deliver the Hunterian Lecture on 21st February, 1950. Subject: Factors contributing to safety in Surgery of the Thyroid.

CHANGES OF ADDRESSES

A. Batty Shaw, M.R.C.P., 42, Trinity Church Square, S.E.1. (Tel. Hop 1101.)

A. C. C. Hughes, M.R.C.P., Selbar House, 82a, Hough Green, Chester. (Tel. Chester 406.)

A. N. Redfern, M.R.C.S., L.R.C.P., 209, Eastgate, Louth, Lincs.

R. A. S. Tipper, L.D.S., 9, Melville Street, Ryde, I. of Wight. (Tel. 2431.)

PAPERS BY GUY'S MEN

Allsopp, C. B. The carcinogenic action of water-soluble substances derived from 3 : 4–Benzpyrene: the effect of Croton oil. *Brit. Emp. Cancer Campaign*, 26th Annual Report, 1948, p. 240.

Atkins, H. J. B. Report on the Mastitis Clinic, Guy's Hospital. *Brit. Emp. Cancer Campaign*, 26th Annual Report, 1948, p. 242.

Bradlaw, R. V. Some trends in dental Undergraduate Education in the United States. *Brit. Dent. J.*, 1949, **87**, 113.

BIRTHS

HANCOCK.—On September 10th, 1949, at St. Teresa's Maternity Hospital, S.W.10, to Betty (née Christopherson), wife of J. Gordon Hancock, B.D.S.—a sister for Susan.

LAWS.—On September 8th, 1949, to Sheila (née Squire), wife of John Laws, M.R.C.P.—a daughter (Jessamy Jane), sister for Judy and Jocelyn.

ROBERTS.—On July 14th, 1949, at Nuffield House, to Margaret (née Goodman), wife of C. Glyn Roberts, M.B., B.S.—a son (Richard Charles).

SWANN.—On September 17th 1949, at Nuffield House, to Mair Christine (née Elsom), wife of G. F. Swann, M.R.C.P.—a daughter (Elizabeth Mary).

MARRIAGES

BACKHOUSE—IZARD.—On September 3rd, 1949, at the Christian Fellowship Centre, Honor Oak, Henry Lewis Backhouse, B.M., to Ruth Minifreda Izard, S.R.N.

JONES—ILETT.—On August 20th, 1949, at Gaywood Parish Church, King's Lynn, Norfolk, Thomas J. Jones, M.B., B.S., to Phyllis Daphne Ilett.

MORRANT—BORTHWICK.—On August 17th, 1949, at Trinity Presbyterian Church, Bromley, Kent, Guy Alistair Morrant, B.D.S., L.D.S., R.C.S., Eng., of Orpington, Kent, to Mary Geoch Borthwick, of Lee, London.

PHILLIPS—FRENCH.—On Saturday, September 10th, 1949, at St. Swithin's, East Grinstead, Surgeon Lieut. (D.) G. G. Phillips, L.D.S., R.N.V.R., to Valerie French.

Eds. {H.A.R. R.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol LXIII. No. 1597 *8th October 1949* *Ninepence*

PASSIM

OCTOBER marks the beginning of the academic year, an important date so far as the Medical School is concerned. Well over a hundred students are entering Guy's for the first time, the majority of them direct from school. They are embarking upon their chosen careers of medicine and dentistry and, in most instances, enjoying the first taste of university life. What do they expect from Guy's and, more significantly, how are they intending to live, work and play in their new milieu ?

The body ultimately responsible for the design of medical education and for the standards of qualification under the various examining bodies in this country is the General Medical Council. Working to the general prescription thus laid down the universities and medical schools are accordingly obliged to follow a relatively standardised pattern. The programme for the medical course covers the basic sciences in the first year, the medical sciences in the next two years and the clinical subjects and experiences for the remainder. Judged on simple logic this natural progress of vocational training can scarcely be faulted. The question is whether the average student is adequately prepared after six years of devoted study along these lines to set forth as a practitioner of medicine, a calling in which success and excellence is assured not by scientific competence alone but " rather by the quality of the inward graces (and) by the kind of culture and character " displayed throughout life.

With the passing of the years and the evolution of the human race the obligations of the individual towards society change, if not in content at least in degree. The demands made upon the medical man become modified in consequence. Difficulties arise because the development of the community is a continuous and inevitable process, whereas the alterations considered desirable to the form of training intended to equip the doctor for his part can be ordained only by statute and then as the result of infrequent and deliberate decisions taken after due and protracted discussion. To-day many feel that the existing curriculum is not altogether satisfactory. Official committees and organisations have surveyed, conferred and reported, while numerous individuals have filled columns in the medical press over the last few years with their criticisms and proposals. Yet the aspiring student still finds that, having elected to embrace in medicine the greatest humanity of all, he must spend months pre-occupied with such exercises as the determination of vapour density by Meyer's method, the malodorous dissection of the dogfish and the unedifying behaviour of steel balls rolling down wooden slopes. Whether this part of the course should be completed at school or left until later is still under controversy and, for the moment, is beside the point. The fact remains, however patronising it may appear to say so, that this early scientific study forms a valuable apprenticeship to logic and disciplined thought and reason, although in itself so divorced in nature from the pure art of healing. Without such novitiation there is almost no other means, later on, of nurturing that faculty on which depend careful observation, detached assessment, critical reasoning and unbiassed judgment—always so long as the experiments are regarded as a means to this end and not as an end in themselves.

With editorial arrogance we maintain that the time spent on chemistry, physics and biology or, indeed, with frog jerks, saponification values, ossification dates and so on, is certainly not wasted. Much of the factual information is fundamental to the practice of medicine for this, as the clinician finds, each week becomes more concerned with pure science. To those longing to get to the bedside we counsel patience (in no sense of a pun) ; learning, even for its own sake, can be adequately justified. A danger nevertheless exists. Devotion to the library and laboratory must not exclude all else. " Studies," as Bacon declared, " may serve for delight, for ornament and for ability," but

they are not the whole of life. " I detect in many doctors and many scientists," wrote Professor T. M. Greene recently, " a failure to achieve a corresponding stage of maturity in other realms—political, social, cultural, religious and esthetic " and he holds the medical schools largely to blame. Particularly is this likely to occur in London where there is such little opportunity for intercourse with members of other faculties. Even though the school authorities may primarily undertake no more than didactic teaching the students themselves should possess enough initiative to do the rest. At Guy's they will find the staff not only distinguished in their own particular fields but the majority of them more than willing to interest themselves, to give up their time and to participate in those extra-curricular activities that are so very desirable.

Sport, to begin with, is such a feature already that it hardly calls for mention and simply to murmur " mens sana in corpore sano " is to verge on the platitudinous. A word, though, about the Clubs' Union Council may not be out of place. This is not, under any circumstances, an arbitrary establishment with autocratic powers. The Union itself, founded in 1891, was a spontaneous fusion of previously independent clubs and societies for the sake of financial and administrative simplification and economy. The constituent institutions jealously guard their identity today, merely agreeing to a convenient form of joint subscription and budgeting which is undertaken by a central body. This Council is made up of representatives of the senior staff, the junior staff and the students, these last being nominated by their respective clubs and societies. Meetings are held quarterly, important decisions are published in the *Gazette* and where matters of major issue are encountered, as only last year on the question of compulsory membership, reference is made direct to the student body.

At Honor Oak Park extensive grounds and pavilion accommodation are available, not perhaps as elegant or in such good condition as many of us would like to see, but the deficiencies, due largely to war damage, are being made good—at great expense. The *Gazette* committee, it may be added, has seen fit to offer considerable financial assistance in this respect.

As for the other activities open to the student they are numerous, and he must make his own choice and follow his own inclinations. Debating, dramatic, musical, art and other societies flourish and welcome further support. To think, to reason, to consider matters other than " shop," and to express oneself clearly and succinctly in both speech and writing is to advance towards intellectual fulfilment. The purpose of the *Gazette* might well be here interpolated. As a " journal of medicine, surgery, dentistry and hospital news," with a circulation figure of over four thousands and a distribution throughout the world, its pages contain articles of scientific interest and advancement, comment, opinion, report and items in a lighter vein, intended for readers at the Hospital, those who have left but still keep in touch and many other besides. The staff claims no monopoly in contribution. Anyone with anything worthwhile to say and write is invited to communicate with the editors. By way of example the majority of the articles in this particular issue are the work of present students.

Guy's has a great tradition and its students unique opportunities. To most undergraduates it offers a full life, a broad education, and an exhilarating existence. The man will be found, however, who prefers simply to partake of that learning which he is given and contribute nothing in return. On qualification it will be said of him, to use Sir Richard Livingstone's words, he " understands everything about his job except its ultimate purpose and its place in the order of the universe."—*Dare quam accipere.*

OWING to pressure of other work, Mr. H. A. Ripman has unfortunately found it necessary to resign as editor of the *Gazette*. He has been associated with its direction since January, 1947. During this time he has given of his services unsparingly and for the competent, determined and able manner in which he has discharged his duties of office he has earned the gratitude not only of those who have been closely associated with him but also the many readers of the Journal.

As the new assistant editor, Mr. P. A. Zorab was appointed by the *Gazette* Committee at a recent meeting. Besides his father, three brothers were at Guy's and another has just entered the Medical School. After war service with the Royal Artillery Mr. P. A. Zorab came to Guy's in October, 1946, and is now a clinical student. An established contributor to the *Gazette* he is recognised as a man of wide interests and truly representative of so many of the undergraduates at the present time.

Milk

ROY GOULDING.

A FEW weeks ago milk was very much in the news. Before the last war the public was exhorted to drink more of it. Now, by contrast, a relative shortage makes newspaper headlines. Since producer and consumer inevitably regard the subject from their separate viewpoints and because their opinions are so often coloured by selfish and even political considerations an attempt is made here to present an objective summary of the industry as a whole. As it is " a highly complex structure whose technological framework has been welded together by countless workers . . . operating from every part of the world," over-simplification will be unavoidable within the confines of a short article. This description will accordingly apply only to the principal stages between byre and kitchen.

Historical.

The oldest written records of the human race are said to be in Sanskrit and preserved in India. They refer to an era about 6,000 years ago. By that time, it is clear, milk was established as an important article of diet and, indeed, wealth was measured largely in terms of kine. A pane discovered near the ruins of Ur of the Chaldees and carved, it is believed, approximately 3,000 B.C. depicts a dairy scene with cows, milkers and various items of dairy equipment and, in the Old Testament, numerous references are made not only to milk but to butter as well. Dried milk, moreover, is no recent innovation, for the soldiers of Genghiz Khan, at large in Asia and Europe during the thirteenth century, are reported to have existed largely upon it and, as for cheese, the Vikings included it among the victuals for their long-boat voyages.

To judge by the writings of Tusser, an agricultural authority of sixteenth century England, both the milch cow and the dairy occupied a prominent place in the husbandry of that period. Obviously then, with the economy of the country almost entirely agrarian, distribution presented no problem. Nearly everyone kept a cow and the labourers not so favoured could easily get supplies from their masters. Butter-making and cheese-processing were developed as convenient methods of preserving the otherwise unusuable surpluses of milk at particular times of the year.

A very different state of affairs arose with the industrial revolution. Large numbers of people were aggregated into urban areas and, in this way, became completely dissociated from the land. Cheap and abundant supplies of so many of the staple and non-perishable foods became available from the freshly exploited continents overseas. Milk, for obvious reasons, could not be procured in this way. Though many town dwellers simply did without, a large demand for " liquid " milk soon arose in the rapidly expanding industrial centres. The pattern of agricultural production changed in consequence. Erstwhile arable farms around the big cities went over to pasture and Essex provided a case in point. Whereas for centuries this county had served as one of the granaries of London, corn growing there proved uneconomic when overwhelming imports of low-priced grain poured into the country after the Repeal of the Corn Laws in 1846. The land which previously had been tilled so assiduously " tumbled down " to grass, the traditional cultivator went his way and the canny stock-keeper from Scotland and the north took his place. Milk production soon became the predominant and certainly more profitable enterprise.

As long distance transport methods improved so, in turn, the milk producers of the west country, keeping their cows more cheaply on the lush pastures of those districts, were able to dispose of their milk on the so-called " liquid " market instead of converting it to butter and cheese as they had done in the past. A host of factors thus combined in the growth of a vast industry, the tangible assets of which in 1939 were estimated at £500 millions for this country alone.

Production.

Characteristic of the production side is the multiplicity of small units so engaged. The total cow population of Great Britain is well over three millions. A very small proportion of these is kept in their ones or twos just to supply the family with milk and cream and the rest are spread over more than 150,000 farms, 43 per cent. of the herds comprising less than ten cows in all. The bulk of the milk, however, is produced from herds of between ten and fifty head of milking stock. More than half the holdings

in this country over five acres in extent are engaged in milk production as a business, either exclusively or in conjunction with other activities. In America, interestingly enough, the herds tend to be rather smaller.

Bare figures of this kind are scarcely descriptive of conditions prevailing on the various farms. The systems adopted vary widely, according to tradition and according to circumstances. Thus, so many of the small farms are essentially family holdings. A few cows find the bulk of their keep from grazing, either on the hills as in Wales, or on the limited pasture as in the home counties. In the winter they are given some hay, some straw and some roots, with possibly some concentrates as well in the form of oats, beans or cattle cake. The buildings into which they are brought for milking or for protection in the severe weather are old, dilapidated and ill-suited for their present purpose. They are dark and lack an adequate water supply. The equipment too, is unsatisfactory and the management, though sound, is conservative and lacking in the enlightened principles of scientific milk production. In fact Morland's paintings of rural scenes executed some hundred-and-fifty years ago could well apply to so many of these farms to-day.

This is not to imply that all small holdings are open to criticism. In a number of instances, progressive farmers are struggling against difficulties—byres that want re-building, yards that want re-flooring, fences that need repairing, apparatus that should be provided, labour that is lacking and, above all, capital that is short. A man and his family looking after a small herd of cows is generally doing a good job and undoubtedly working harder than most people to-day. Holidays are not for them. Every morning, winter and summer, the milking has to be done, even before the rest of the world is awake. Often it is cold, wet and dark. Hands are frozen and habit alone makes for competence when the eye can see so little. Or the weather is hot, flies are a menace and the cows will not stand still. Water then, may be scarce and the pastures so burned by the sun that the feed they provide is negligible. Every afternoon, milking time comes round again. Meanwhile dung has to be shifted from the sheds and yards, straw carted, hay made, roots cultivated and corn cut. The milk must never be late or the lorry will not collect it. If the yield falls the family income is reduced proportionately. And then there are coupons to be dealt with—for all purchased cattle foods are on ration, and the Milk Marketing Board returns and Ministry of Agriculture forms to be completed. Without doubt this is no mere occupation—this is a way of life and no palmy one at that.

The large farms rely more on paid labour. Time-off for the workers can then be arranged. Again, various systems of management are practised. On the Wiltshire downs, for example, the " bail " is widely favoured. This is virtually a portable milking shed. Throughout the year, fair and foul, the cows graze at large. Twice a day they are driven into an improvised compound and pass, in their twos and threes, through the " bail," being milked mechanically in the process and getting a measured allowance of concentrated foods at the same time. Two men will look after such an outfit and in the depth of winter this is no sinecure. In the eastern counties and other lowland areas a more intensive method of operating is commonly followed. The grazings are all fenced and treated with the same care as the arable land. Quite elaborate steadings and covered yards are furnished for the stock. Milking may be by hand or machine and sometimes what are termed " milk parlours " are fitted out which, by their sparkle, glass and steel, bear comparison with any modern operating theatre. Not only are the animals most carefully looked after but their yields are accurately recorded and their rations, devised by scientific calculation, are allocated accordingly.

The cow is essentially a herbivore and the bulk of her keep is derived from coarse fodders—grass, hay and straw. What is more, she is by far the most efficient converter of plant growth to human food, furnishing 39 lb. protein as whole milk from one acre of land in the course of a year. None the less, her digestive organs are delicate and the high-yielding animal requires, in addition, a properly balanced allowance of concentrates as cereals, legumes or oilcake.

Estimates put the average yield per cow in this country at something over 500 gallons per year and this figure is very little lower than what it was before the war, notwithstanding the shortage of imported feeding stuffs to-day. Incidentally, in the U.S.A., the corresponding figure is about 10 per cent. lower. Nevertheless, in some herds, the yields are nearer a thousand gallons per cow per annum, while individual animals are credited with achievements of over 3,000 gallons. Plainly then, in other instances, the output must be dismally low. The amount of milk which can be drawn

from a cow depends partly on her hereditary potentialities and also on the way in which she is fed and looked after. If high standards can be attained on some farms there must be room for improvement on the others. This entails revised breeding policies, more facilities for artificial insemination, the provision of convenient buildings and suitable equipment, control of disease and more enlightened management. The responsibility for inspiring progress along these lines rests principally with the National Agricultural Advisory Service set up by the Government at the end of the last war.

For all the defects apparent at the present time the total production of milk in the country is now about 1,400 million gallons annually, an amount which is almost equal to the 1937–38 level when unlimited supplies of imported animal feeding-stuffs were obtainable. In value this accounts for approximately one-third of the total agricultural output of the country. Furthermore, by attracting more milk onto the market and diverting more from manufacturing purposes the Milk Marketing Board made available to the public in "liquid" form some 1,242 million gallons in 1946–47 compared with 767 million gallons in 1938–39.

Production through the year varies from month to month, the maximum being registered from May to August when, in a normal season, grass is plentiful. An official price structure has been formulated by which more is paid per gallon during the months of scarcity. Farmers therefore attempt to take advantage of this by planning their calvings towards the "back-end," more cows then being in profit during the winter months. By this means official policy has, to some extent, ensured more level deliveries.

Distribution.

Of the total price paid by the consumer for his milk half of it is accounted for in the costs of distribution. Some farmers in the neighbourhood of towns are "producer-retailers." They deliver milk direct to their customers from the farms at which it is produced, sometimes processing it in addition. Others, a majority, dispose of their supplies to wholesalers. On the farm the milk is first cooled and then run into 10 gallon churns. These are transported by road, and occasionally by rail, to the "county creamery." There the consignments are checked and weighed, and submitted to preliminary testing. After being cooled once more the milk is moved in bulk, again by road or rail and usually in glass-lined tankers, to the "processing depot." Further testing is then conducted and pasteurisation proceeds at the rate of 500–4,000 gallons per hour. The milk is then run into bottles or churns, usually mechanically, and these are capped or sealed. It is sent out next to the distributing depots where it is kept in refrigerators prior to street delivery. At this final stage, Davies has calculated, one roundsman may well handle a ton of milk and metal in a day.

Technically all milk is purchased by the Ministry of Food and re-sold ultimately to the consumers. The Milk Marketing Board acts in the capacity of an agent for these transactions. Standard prices and payments—wholesale, retail and in respect of transport and other services, are determined by the Ministry of Agriculture after consultation with the producers' and trade organisations.

Distribution, both nationally and locally, is supervised by the Ministry of Food and the Milk Marketing Board. Retailers are entitled to draw such quantities for sale to their customers as are covered by the number of registrations on their books, taking into account the priority classes—expectant and nursing mothers, infants, school children and invalids, together with a 10 per cent. margin for emergencies, wastage and the like.

Cleanliness and Safety.

Except where the udder is diseased the milk, as it leaves the cow, is virtually sterile. But bacterial contamination begins at once. Stenhouse Williams, some years ago, put the annual nett losses from souring at some £400,000 and as this is due, almost entirely, to bacterial activity the value of preventive measures requires no emphasis. The cows are kept clean, sheds are washed down, equipment is thoroughly sterilised and the workers observe hygienic precautions. Thereafter, the milk is strained and effectively cooled as soon as possible. By such means the growth of those organisms which contrive to gain entry is inhibited to a considerable extent. In addition, heat treatment may reduce the active bacterial content further, but pasteurisation will never convert dirty milk into a wholesome sample.

Of the pathogenic agents M. tuberculosis is by far the most serious. 40 per cent. of the cattle in Great Britain are reckoned to be infected, most of them in the lungs. Only the 0.5 per cent. with tuberculosis of the udder are likely to transmit the disease

to man. Nevertheless, bulk samples of milk examined by Minnett and Pullinger showed the acid-fast organism in some 20 per cent. The infected cow cannot always be detected, the tuberculin test is not infallible and complete eradication so widely advocated is an expensive and long-term project. Proper heat treatment is the only safeguard.

As for undulant fever, 40 per cent. of the cows in the country are said to be infected with B. abortus and among the samples of market milk examined, probably 25 per cent. contain the organism. Extremely few clinical cases are reported among humans and in any case B. abortus is killed by heat treatment.

Milk-borne epidemics have occurred with typhoid fever, dysentery and various streptococcal infections. Somewhat surprisingly outbreaks nowadays are no more than occasional.

As with any business in which the handling of food may have repercussions on the public health, the only real safeguard is an awareness and sense of social responsibility on the part of the workers concerned. Legislation can but insist on the enforcement of certain minimal standards and to this end a comprehensive collection of Acts, Orders and Regulations covers the various aspects of the milk industry.

Legislation.

In the first place, cow-keepers from whose premises milk is sold for human consumption must be registered. Previously they did so with the local authority on behalf of the Ministry of Health. Since 1st October, 1949, when the appropriate regulations made under the Food and Drugs (Milk and Dairies) Act, 1944, came into force the official body charged with this duty has been the Ministry of Agriculture. County Milk Regulations Officers are being appointed under this department. Permission to carry on the business of milk production is granted only when the buildings, their construction, the water supply and the drainage are deemed satisfactory. Licensing is also necessary under the Ministry of Food and the Milk Marketing Board.

By the terms of the Agricultural Marketing Act, 1931, its subsequent amending Acts and the Defence (Agriculture and Fisheries) Regulations, 1939, milk must be disposed of in accordance with the terms and conditions stipulated by the Milk Marketing Board as regards price, buyer, grading, packing, transportation, etc.

The Food and Drugs Act, 1938, makes it a punishable offence to sell milk for human consumption which is known to have come from a cow suffering from tuberculosis with emaciation, tuberculosis of the udder, suppurating sores of the teats, septic condition of the uterus, a comatose condition or any condition of the udder or teats likely to contaminate the milk.

The onus is upon the farmer to notify his local authority of the incidence of certain diseases among his cattle and of particular infectious diseases among his workers handling the milk. The local Medical Officer of Health may then demand a list of customers for the purpose of investigating an outbreak of milk-borne disease in the community.

Regulations provide for the cooling of milk as soon as possible after its production and for its storage subsequently. Milk churns and other vessels must be sealed after filling and must be used for no other purpose than to contain milk. Instructions are issued under the Milk and Dairies Regulations, 1943, regarding the cleaning and sterilising of all utensils.

All milk offered for sale must be genuine and unadulterated. Under the Food and Drugs Act, 1938, and the Sale of Milk Regulations, 1939, any sample of milk which is found on chemical analysis to contain less than 3 per cent. butter-fat and/or less than 8.5 per cent. " solids-not-fat " shall be presumed not genuine by reason of abstraction or adulteration until the contrary is proved.

Graded Milks.

By the Milk (Special Designations) Orders of 1936 and thereafter, together with the subsequent regulations, milks attaining to a particular quality of cleanliness and others having undergone heat treatment may be designated in certain grades. Thus milk to be sold as *Tuberculin Tested* must be obtained from cows which, under the *Attested Herds Scheme*, are found to give negative tuberculin reactions at least twice a year. When the milk is actually bottled on the farm it is referred to as *Tuberculin Tested (Certified)*. Cleanliness is assessed according to the standard methylene blue test and the presumptive coliform test, both of these being carried out on routine samples taken at regular intervals. *Accredited* milk must come from farms which are regularly inspected

and the cows examined clinically, but the tuberculin tests are not applied. Bacteriological standards for this milk are otherwise the same.

For *Pasteurised* milk no conditions as to the health of the herd are prescribed. The form of heat treatment employed, however, must be officially recognised, either the "Holder"—heating to 145° F. for ½ hour, then cooling to 55° F., or the "H.T.S.T."—heating to 163° F. for 15 seconds, then cooling to 55° F. Final samples of the milk must not discolourise methylene blue within half-an-hour, must not contain more than 100,000 bacteria per ml. and must not give a phosphatase test of 2.3 Lovibond Blue units or less. Milk from Attested Herds, as above, may be heat treated and sold as *Tuberculin Tested (Pasteurised)*, when it must conform to the other pasteurising standards except that the bacterial content must not exceed 30,000 per ml.

In time, no milk will be sold to the public unless it comes into one of the designated grades already described. This policy will be implemented through the Milk (Special Designations) Act of 1949.

National Milk Testing and Advisory Service.

This scheme was started by the Ministry of Agriculture in 1942. Regular testing of the milk supplied by individual producers is conducted at the point of delivery—creamery or dairy. Keeping quality is the criterion. Every churn arriving at the unloading dock is inspected by the platform examiner. Samples that are suspect, either by previous history or by abnormal smell or appearance, are submitted to a simple, rapid ("10 minute") resazurin (dye discolouration) test. The results are classified A (*market standard*), B (*manufacturing standard*) or C (*rejection standard*). Milk coming into the first category is accepted and goes into the main bulk; that in the second category is used for manufacturing or for prompt, local delivery; that in the third category is returned at once to the producer. Completely unsatisfactory milk is in this way kept off the market.

Another resazurin test known as the "Standard Routine" is applied twice a month to each producer's milk. Again the same categories are recognised. To those farms from which milk is delivered of a poor quality as determined by this procedure, advisory visits are paid by officers of the County Agricultural Committee. Where persuasion fails to effect any improvement, official pressure can then be brought to bear.

CONSUMPTION.

Cows' milk normally contains about 3–3½ per cent. protein, 4–5 per cent. sugar, 3½–4½ per cent. fat, 0.7 per cent. inorganic substances and 87–88 per cent. water. It is a useful source of vitamin A, riboflavin, nicotinic acid, calcium and phosphorus. It provides a modicum of vitamin B_1 a variable quantity of vitamin D, but no more than a trace of vitamin C. In iron it is notably deficient. Variations in composition depend upon the breed and age of the cow, the season of the year, the feeding and management and the time that has elapsed since calving. To claim it as a perfect food is to exaggerate. As the sole article of diet it is too bulky, contains too little iron and is not completely assimilable. For all that, it has greater nutritional potentialities than any other single commodity.

Infant Feeding.

The desirability of suckling the infant at the breast has already been stressed in these columns.* Where, however, the natural source fails, cows' milk, in some form or another, is the most reasonable alternative. Yet because the difference in composition is appreciable, careful modification is demanded if the infant is to thrive.

Invalids.

By Hippocrates, Galen and Celsus milk was accepted as a "sovereign remedy." In arranging an invalid diet it is of outstanding value, for it is easily swallowed, is thirst quenching, is non-irritant to the digestive tract, is rapidly assimilated and provides for practically all the nutritional requirements. Nevertheless, individuals are occasionally encountered who are sensitive or even allergic to it.

Adolescents.

Corry Mann's experiment may be cited with numerous others as demonstrating to what a remarkable degree the growth and attainment of schoolboys can be beneficially influenced by including extra milk in their diet. Nowadays the idea of more milk for the growing child is widely accepted.

*Ripman, H. A. "Endocrines and Lactation." Guy's Hospital *Gazette*, lxvii, 1500, 20th July, 1949.

Adults.

Liquid milk can hardly be quoted as a "natural" food for adults. The human alone, of all the animal species, continues to consume it past the stage of weaning. Although very desirable it is certainly not indispensible, but it has the particular merit that in the culinary art it can be incorporated in so many dishes and utilised for so many purposes.

Prior to 1939 the quantity of liquid milk consumed in the United Kingdom worked out at about 217.7 lb. per head per year. By 1943 the figure had risen to 291.6 lb., an increase of 34 per cent. To-day the level of consumption is no lower; indeed it is probably higher still. The relative shortage lately experienced is therefore entirely due to increased demand. Special allocations are made to the priority classes—nursing mothers, infants, school children and invalids. The general public as a whole is drinking more milk as well. The farmer is maintaining and even raising the output, the Government, through the Milk Marketing Board, is directing still more on to the "liquid" market. Yet the appetite remains unassuaged.

QUANTITY OF MILK SOLD THROUGH MILK MARKETING BOARD.

October–September	Disposal.			
	Total	Liquid	Manufacture	Per cent. Manufacture
	Million gallons.			
1933–4	855.62	642.79	212.83	25.1
1934–5	980.96	665.26	315.70	32.2
1935–6	1,023.96	663.80	360.16	35.2
1936–7	989.86	681.05	308.81	31.2
1937–8	1,063.13	752.20	310.93	29.2
1938–9	1,118.70	766.82	351.88	31.5
1939–40	1,070.72	788.75	281.97	26.3
1940–1	1,044.92	926.34	118.58	11.3
1941–2	1.079.18	971.49	107.69	10.0
1942–3	1,145.02	1,017.19	127.83	11.2
1943–4	1,180.22	1,047.84	132.38	11.2
1944–5	1,204.22	1,071.10	133.12	11.1
1945–6	1,258.93	1,131.75	127.18	10.1
1946–7	1,242.70	1,144.77	97.93	8.6

The Advisory Committee on Nutrition of the Ministry of Health declared, in 1937, that "the desirable amount of milk is, for children from one to two pints per day; for expectant and nursing mothers about two pints a day, and for other adult members of the community half a pint of milk daily." Bransby and his collaborators have calculated that on such a basis the total quantity of "liquid" milk required by the population is 50 per cent. above that consumed annually in the period 1934–38 and 25 per cent. above that actually available in 1945–46. Opening up before the dairy industry of Britain, then, is a great future. The supply of clean and safe milk can be vastly expanded before the danger of anything but a transient surplus need ever arise.

For references consulted in connection with this article I am very grateful to Mr. B. H. Harvey, *Principal of the Essex Institute of Agriculture*, for furnishing statistics I acknowledge the help of the Milk Marketing Board and for library facilities I am indebted to the Ministry of Agriculture and Fisheries.

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A Man and His Manœuvre

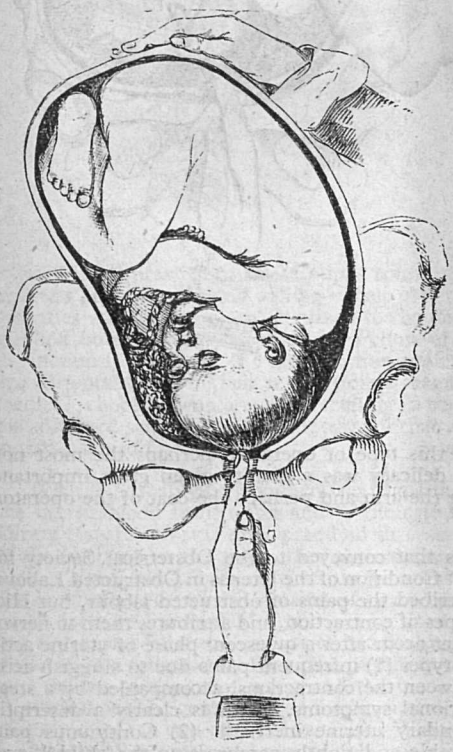
JOHN BRAXTON HICKS—A BIOGRAPHY

(1823–1897)

ADDISON, Bright, Hodgkin and Wilks are names that shine in the world of medicine. Such were the men in part responsible for gaining Guy's its high reputation. Yet little is heard about the famous Guy's men of obstetrics. Amongst them, nevertheless, was John Braxton Hicks.

The second son of Edward Hicks, a Hampshire banker and county magistrate, John Braxton Hicks was born at Rye in Sussex in 1823, his mother being on holiday with relatives at the time. Of his early life we know little, except that he was educated privately by Rev. Zillwood of Compton Rectory, near Winchester. At the age of nineteen he became apprenticed to the local practitioner—one Dr. Fluder—from whom he learnt the rudiments of his profession.

On entering the medical school of Guy's in 1841, Hicks at once showed promise of a brilliant career. Anatomy was at the time taught by Mr. (later Sir Astley) Cooper and Mr. Cock of " Cock's peculiar tumour " fame, and materia medica by Dr. Addison. Hicks gained honours in all subjects and a scholarship in materia medica on passing his 1st M.B. in 1843. Proceeding to his clinical studies he became dresser to Mr. Aston Key and Mr. Morgan, and medical clerk to Dr. Addison and Dr. Babington. The degree of M.B. was attained in 1847. It is interesting to note that during his student days he was a contemporary of Samuel Wilks.



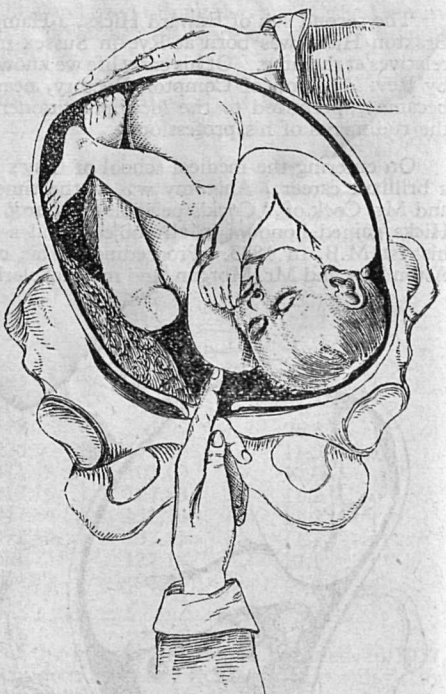
Private practice called him on the completion of his house appointments and in 1849 he went into partnership at Tottenham with a Mr. Moon. It is said that he was held in high esteem by his patients during his ten years' stay amongst them. Ten years later Hicks was invited to return to Guy's and in 1859 he was appointed assistant obstetrical physician, remaining on the staff of the hospital until his retirement in 1883.

Braxton Hicks was not a great writer or speaker, but a perusal of his papers immediately shows that he was an astute clinical observer. In all, he wrote some forty papers, many of these being presented to the Obstetrical Society of London, of which he was one of the founders and its President in the years 1871–2.

In July, 1860, a paper appeared in the *Lancet* on " A New Method of Version in Labour," this being the first news of perhaps his most well-known contribution to obstetrics. Three years later he read a paper to the Obstetrical Society of London on the same subject, it now being sufficiently established to allow satisfactory discussion. The illustrations appearing with this article are reproduced direct from the original paper published in the Transactions of the Obstetrical Society in 1867, and acknowledgment is made to Messrs. Longmans in so doing. Before this time version had entailed the introduction of the whole hand into the uterus, and had

been a measure adopted only late in labour. Lee of St. George's had described what he called " two-finger turning," and some Germans, notably Martin and Carl Esterle, had demonstrated the possibility of turning the fœtus from the outside. Hicks, in his paper, described his method of combined external and internal version and summed up his reasons thus : " Anything which gave the practitioner some power of action was earnestly to be recommended, anything better than to stand with folded arms, incapable of rendering assistance for hours or even days, every moment of which might be carrying the sinking and suffering patient nearer to the grave."

The actual technique was described by him as follows :—" Having lubricated my hand I introduce it as far into the vagina as necessary to reach a finger's length within the cervix. Having clearly made out the head and its direction I place my right hand on the abdomen of the patient and endeavour to make out the breech. The external hand presses gently but firmly the breech to the right side ; as it recedes so the hand follows it by gentle palpation while at the same time the other hand pushes up the head in the opposite direction so as to raise it above the brim. When the breech has arrived at about the transverse diameter of the uterus the head will have cleared the brim and the shoulder be opposite the os. That is pushed on in like manner as the head and after a little depression of the breech from outside the knee touches the finger and can be hooked down by it."



His use of this method of version in the management of placenta prævia is described as follows :—" When the foot has arrived at the os I rupture the membranes, draw the foot and leg through as far as they will descend without force. By exerting gentle traction with merely the weight of the arm we have a firm plug on the bleeding part."

" Turn, and if you use the child as a plug the danger is over. Then wait for the pains, rally the powers in the interval and let nature, gently assisted, complete the delivery."

Among the advantages claimed for this type of operation perhaps the most noteworthy, especially in those days when delicacy was a quality given great importance, was that even " the necessity for baring the arm and perhaps the coat of the operator " was obviated.

Hicks' next main original work was that conveyed to the Obstetrical Society in a paper read in 1867 on the subject of the " Condition of the Uterus in Obstructed Labour." Murphy and Rigby had previously described the pains of obstructed labour, but Hicks clearly differentiates them from other types of contraction, and attributes them to nervous exhaustion of the uterus. The pains that occur after a quiescent phase of uterine action were, according to him, of two distinct types (1) infrequent pains due to sluggish action of the uterus, with a period of rest between the contractions, accompanied by a steady pulse and no gross untoward constitutional symptoms. This is clearly a description of what Scanzoni later termed " secondary uterine inertia." (2) Continuous pains, the uterus becoming irregular and irritable and tightly compressing the child " every indentation as it were forming a ledge past which it is difficult to draw the child or to pass the hand if it were desired to turn." What a clear description of tonic contraction of the uterus, or what Eardley Holland has since called " active retention of the fœtus."

Hicks, in this paper, also calls attention to the danger of a post-partum hæmorrhage being produced by hasty extraction of the child from a relaxed uterus.

More papers followed on a variety of subjects including the anatomy of the human placenta, face presentation, rupture and inversion of the uterus, the use and types of the cephalotribe, uterine polypi and puerperal sepsis. Braxton Hicks' sign is described in a paper entitled " On the Contractions of the Uterus during Pregnancy, their Physiological Effects and their Value in the Diagnosis of Pregnancy," read in 1871. He describes the fact that the uterus possesses the power and habit of spontaneously contracting and relaxing from a very early period of pregnancy, and goes on to say, " It is interesting to notice during the gradual increase of solidity how the presence of the fœtus, quite distinct before, slowly becomes more indistinct, while the outline of the uterus slowly becomes more clearly marked, till instead of the fœtus we find a hard globular swelling which we could, at the time we recognised the fœtus, scarcely feel at all." He emphasises the purely physiological function of these contractions and attributes their functions to the provision of a free movement of blood in the uterine wall and to the maintenance of the vertical lie of the fœtus in utero.

What of the man himself? An acquaintance describes him as having an amiable, cheerful expression, with bright piercing eyes and a noble forehead. There are numerous descriptions which emphasise his enthusiasm, his careful attention to detail and his painstaking methods of teaching. Believing that social attributes were essential to a practitioner of medicine, it was Hicks' practice to invite pupils round to his home in No. 9, St. Thomas' Street, and was always ready and willing to help in both financial and non-financial matters. His activities were by no means confined to the field of medicine, indeed he was a distinguished botanist and was elected a Fellow of the Royal Society in 1862, surely a rare distinction for a doctor in regard to non-professional work. A collector of Wedgewood and Oriental china he had at one time a magnificent collection in his home. While at medical school he won a cup for sculling in the Hospital boat club. Of his personal life his son once said, " At home he was all that a husband and father could or should be ; to that I can add nothing."

What is probably little known was that Braxton Hicks was one of the first to describe the use of blood transfusion and to indicate the practical necessity for anticoagulants. Direct transfusion was only practised in cases of dire need, this entailing the presence of the husband in the room, the whole scene being " appalling to a man never used to such a sight and conscious that his wife was in extreme jeopardy." Hicks mentions the inconvenience of the clotting of the blood and the danger of embolism, and goes on to describe his method " not in a spirit of boasting, nor of urgent recommendation, but rather as a hint and earnest of better things to come." He recommends that phosphate of lime (advised by Pavy, the physician to the hospital) be mixed in the proportion of 3 ounces to a pint of water and the blood diluted to the proportion of 4 : 1. The mixture should be gently stirred, being careful to avoid bubbles, and injected in quantities of not more than two ounces at a time. What his opinions would have been on the value or dangers of reconstituted plasma and gum saline transfusions we can only surmise !

Hicks was on the staff of Guy's for twenty-four years and on being appointed Consulting Obstetric Physician in 1883 felt that his teaching services were being disposed

of and so accepted the post of obstetrical physician to St. Mary's Hospital, a double connection which must indeed be a rare occurrence. He remained loyal, however, to his own hospital and never forgot that he was a Guy's man. Other hospital appointments were held at the Royal Maternity Charity and the Royal Hospital for Women and Children in the Waterloo Road.

On his retirement he lived at his old home at Lymington in Hampshire and stayed there until his death in August, 1897, from heart failure following several attacks of influenza. He was buried at Lymington. No better tribute can be given him than that published in the Guy's Hospital *Gazette* of September 11th, 1897, "In Dr. Braxton Hicks we lose one of the most distinguished members of our consulting staff, a man who in his own branch of the profession held a world-wide reputation of sound scientific achievement and originality."

JOHN W. HUGHES.

Lectures in Brief—V.

LARGE BOWEL OBSTRUCTION.

By Mr. GUY BLACKBURN.

THIS is a condition most commonly seen in patients over sixty years. It is predominantly due to Carcinoma Coli, which in fact accounts for approximately nine cases out of ten. Of the other causes, diverticulitis and fæcal impaction (particularly in the bedridden), are the commonest, and less frequent are congenital atresia, congenital megacolon, spasm and stricture. After the age of eighty, malignant disease of the large bowel is uncommon, and in patients older than this, large bowel occlusion is most often due to volvulus. Of the carcinomata, two-thirds are found on the left side, and of the remaining third approximately equal numbers are found in the ascending and transverse colon, whereas only half as many are found at the two flexures together. Carcinoma of the cæcum, because that segment of bowel is particularly distensible, because the fæces are fluid, and because the growth is not encircling, very rarely causes a stoppage.

The symptoms of large bowel obstruction are the renowned constipation, colicky abdominal pain, distension and vomiting. This last is a late occurrence, and when fæculant, too late. The process is commonly slow, with often an acute episode superimposed. On examination the patient is found to be apyrexial with a raised pulse rate, often displaying no evidence of loss of weight. The distension is peripheral rather than central, as in small bowel obstruction, the condition in which visible peristalsis is seen. In the old patient appendicitis, which may not be the fulminating condition that it is in the young, may not only simulate very closely, but, in fact, produce obstruction. A straight X-ray taken in the erect posture may be helpful, showing gross gaseous distension and fluid levels. This is not, however, always diagnostic.

Treatment in the first instance is that of a dehydrated patient who is a bad operative risk. An enema (or two) and the Miller-Abbot tube, by which means the gut is decompressed and patency sometimes re-established, may permit the exhibition of insoluble sulphonamides. Parenteral fluids, together with a more comprehensive understanding of the changes in blood chemistry in obstruction and advances in anæsthesia, have gone a long way towards substituting delayed definitive surgery for preliminary colostomy. Once the threat of acute obstruction has been eliminated intraperitoneal resection with end-to-end anastomosis and without cæcostomy is no longer the heresy it was. When, however, it is inapplicable, for tumours of the pelvic and transverse colon the Paul-Mickulicz operation in three stages (exteriorisation, resection with crushing of the spur and colostomy closure), is a safe measure.

For obstruction due to diverticulitis, transverse colostomy is the treatment of choice. In rare instances, where the disease is confined to a localised segment of bowel, subsequent resection may be deemed advisable.

H.A.R.

Royal Photographic Society

The annual general exhibition of the Royal Photographic Society opens at 16, Prince's Gate, Kensington, on Saturday, October 8th, and remains open until October 26th. In the Scientific Section, in which there was intense competition among exhibitors, the Photographic Department of the Hospital has had a number of works accepted, namely two sets of prints (Bell's Palsy and Penicillin Dermatitis), one set of colour transparencies (Mycosis Fungoides) and a colour film (Ballismic movements)—the only medical film on show.

Mediterranean Anæmia

B. H. BASS.
At the Yale School of Medicine, New Haven, U.S.A.

MEDITERRANEAN ANAEMIA, otherwise referred to as the Erythroblastic Anæmia of Cooley, is an erythron dystrophy considered to be congenital in origin. Essentially, the red cells are thinner and more resistant to hypotonic saline than normal. Under the microscope they are to be seen in the peripheral blood as oval or target-shaped bodies or as large, pale, leaf-like structures. There is hypochromia and an excess of nucleated red corpuscles and immature white cells.

Clinically this abnormality is confined to persons of Mediterranean stock. It has been regarded as a chronic, progressive and invariably fatal disease of children, associated with spleno- and sometimes hepato-megaly, mongoloid facies, a greenish pallor of the skin and generalised bony changes resembling osteitis fibrosa and due to hypertrophy of the marrow. Nevertheless, other members of affected families may show the abnormal type of red cell without manifest anæmia or with only very mild symptoms.

CASE DESCRIPTION.

The patient, a girl nineteen years of age, was born in the U.S.A. of Italian parents and now lives in New Haven where more than half the population are of Italian extraction.

Family history—Nil relevant. *Previous illness*—None.

Present illness. The patient was first seen in 1930 when only four-and-a-half-months old. She was brought to Pædiatric Out-Patients because of "anæmia," failure to take feeds properly and slight pyrexia. On examination she proved to be an anæmic, poorly-nourished infant with a somewhat olive tint to her skin. The heart was clinically enlarged to the left and a "to-and-fro" murmur was heard over the entire præcordium. The liver was enlarged three finger-breadths below the right costal margin. The spleen was not felt. The blood picture showed a red-cell count of 2.84 million, a white cell count of 17,000 and hæmoglobin of 38%. X-rays showed slight increase in the density of the areas of calcification in the diaphyses of the long bones.

Agglutination tests with anti-sera were negative at all times.

The diagnosis then made was *anæmia secondary to malnutrition* and treatment was transfusion of 300 ml. of whole blood.

The next admission was in November 1930, again for "anæmia." On examination then the patient appeared as a very pale infant who refused food. Her temperature was 100°F. Her spleen was enlarged to the iliac crest on the left and the liver to the umbilicus. The blood picture revealed a red cell count of 2.4 million, a white cell count of 15,000 and hæmoglobin of 30%. Peripheral smear showed numerous immature white cells and also normoblasts and reticulocytes. The fragility of the red cells was slightly decreased. The serum gave an indirect van den Bergh reaction and the urine contained no bile or urobilin.

The diagnosis reached at this stage was *spleno-hepato-megaly with anæmia* (? *Cooley's anæmia*). Treatment by transfusion with whole blood was again successful.

During 1930 two more transfusions were performed.

In February, 1931, when the patient was ten months of age, she underwent splenectomy. The pathologist's report on the spleen stated that it measured 7 x 5 x 3 cm. and had a smooth, glistening capsule. The anterior border had a marked splenic notch. On section the pulp was dark-red, interspersed with numerous small nodules which were probably hypertrophied malpighian corpuscles. The pulp was increased in amount and the sinusoids markedly compressed, while the pulp contained numerous erythroblasts and myelocytes.

Over the next three years the patient was admitted to the hospital several times for transfusion on account of her anæmia. On occasion the hæmoglobin fell as low as 15%, with a red cell count of 1.5 million. Development of the mongoloid facies was also observed.

In November, 1934, the heart was found to be enlarged and a systolic apical murmur was heard, presumably of "hæmic" origin.

Nothing further of significance occurred in the history until 1947, but in the meantime the patient was being constantly re-admitted for transfusions. Then, in 1947, the heart was found to be more enlarged and, on auscultation, there was gallop rhythm and ventricular extra-systoles. The liver was enlarged to the pubic symphysis. An E.C.G. showed a heart rate of 80 per minute, the PR interval being 0.21 second and the T-waves flattened in leads I and II.

First degree auricular-ventricular block was diagnosed and the physicians considered that she was in mild, anæmic, cardiac failure. Treatment with quinidine and digitalis was successful.

X-ray of the skull showed generalised osteo-porosis and there was increased mottling with a mosaic pattern in the ribs. In the clavicles and long bones the trabeculation was increased and cystic areas had invaded the entire clavicle on one side.

The patient's last admission was in June, 1949—her hundred-and-first !—and the liver was then found down in the pelvis. Hæmoglobin was 30% and the red cell count 2 millions. In the peripheral film many erythroblasts were seen and the red-cells noted to have the peculiar leaf-shape. She was again treated by transfusion with whole blood and is naturally expected to appear in the ward again for similar therapy as soon as the anæmia demands it.

Cooley's anæmia, although common in Mediterranean areas, occurs not infrequently in practice in New Haven where the population is so largely of Mediterranean stock.

I should like to thank Dr. Hugh Dwyer, M.D., F.A.C.P., for permission to present this case.

Students' Health Service

BETWEEN October 18th and October 28th a mass miniature radiography unit is again being sent to Guy's in order to X-ray the students and the administrative and technical staff of the Schools. The nurses, together with students in the Physiotherapy and Radiology Schools, will also be examined.

In order that the unit may be used to best advantage and the large number of skiagrams taken with the greatest economy of time, it is very important that the organisation should proceed smoothly. Notices will be posted in the Medical School, Dental School, Colonnade and College stating the time at which each student should attend for this X-ray examination. If a student does not find his name on the list he should apply to the Secretary to the Students' Health Service for an appointment. The appointments for students doing preclinical studies have been arranged in " years," and arrangements have been kindly made by the Dean and the Heads of Departments concerned to make it possible for everyone to attend at the appointment time. Appointments for students in their clinical years have been made on days that as far as possible are convenient for them, but it will be appreciated that there must be many cases where the appointment conflicts with some other duty. As the radiographic examination will only take a few minutes, it is hoped that everyone will keep his appointment even though this may mean some inconvenience in a few cases. Working out a timetable has been a complicated matter and I regret that it is impossible to change the times of appointments.

The Dean has agreed that this examination should on this occasion take precedence over other School activities. The School Council has decided that attendance for routine medical and radiological examination is a condition of studentship.

No timed appointment has been made for House Officers. Each Resident should, however, telephone the Secretary to the Students' Health Service who will then make an appointment which is mutually convenient.

I hope that we shall be able, by this method, to X-ray the whole of the School. Such examinations are of enormous importance in discovering cases of early tuberculosis which still remain a frequent misfortune among medical and dental students and House Officers.

If the miniature film is normal, the student will hear nothing further about it; if its appearances suggest abnormality, or if it is inconclusive, the student will be asked to attend for a full size film to be taken. It must be realised, however, that to be asked to attend in this way does not mean that the student has any disease of the lungs necessarily; it may mean simply that the miniature film gives insufficient detail for a final conclusion to be drawn.

W. N. MANN.

Correspondence

Guy's Hospital Reports

SIR,—A number of your readers may not have thought of subscribing to the Guy's Hospital Reports ; some may not even be familiar with it.

As a scientific hospital journal it holds a unique position. In spite of many difficulties publication was maintained throughout the war, and it is now as strong and flourishing as ever during its 113 years of life. The costs of printing and publishing have, like everything else, greatly increased and threaten to overshadow the income from subscriptions. It would be a great help if all Guy's men and women who are not subscribers would become so. The annual subscription is £2 2*s*. but students and newly qualified people are eligible for a reduced subscription of £1 1*s*. for a period of two years after qualification.

Mr. Winston, the librarian, will be pleased to take the names of those who wish to receive the Reports. Payment is best made by Banker's order.

Yours, etc.,

R. C. BROCK }
W. N. MANN } *Editors.*

Guy's Hospital, S.E.1.

Staff Location System and Meals

SIR,—The procedure in operation for getting in touch with registrars, housemen and others required in various departments of the Hospital, is a great improvement on that which obtained previously. Much more co-operation between the various parties concerned is, nevertheless, very desirable.

Considerable delay so often ensues between putting out a flash and the appropriate person answering it. Even if a houseman is on a round with his Honorary surely he could be spared and excused for a few moments to answer his call, thus saving time in other departments. The long intervals which now follow the issuing of a call and a response by the person concerned leads to much ill-feeling and not infrequently to a few expressions, the precise nature of which can scarcely be recorded here.

What is required is what the Americans no doubt would call " flash consciousness." The whole system should be reset and checked at least twice weekly.

Much sympathy is extended to members of take-in firms who cannot reach the College at the proper times for their meals. When they wish to have meals reserved they should be able to do so by getting into touch direct with the catering manageress or supervisor. If the College porter is left to act as intermediary he must neglect his lodge and the telephones therein to an unjustifiable extent. Moreover, although the porter cannot refuse to approach the manageress or supervisor she can still refuse any requests made after 7.30 p.m.

May we suggest that these difficulties could be obviated by the provision of a house telephone in the cashier's desk ?

Yours, etc.,

THE COLLEGE PORTERS.

Guy's Hospital, S.E.1.

Hunt's House

There are wards and ailing patients in the place they call Hunt's House,
There are masses of films and an X-ray and students without much nous.
And I think there's a sort of a reason for fitting a turnstile, too,
But don't think they'll charge you a shilling as they do when you go to the Zoo !

(*With apologies to A. A. Milne.*)

The answer is, simply, that the statisticians are checking just how many people use the lifts, before new ones are installed.

Sport

RUGBY FOOTBALL

Guy's *v.* Blackheath

At H.O.P. Drew 9—9.
24th September, 1949.

Guy's began shakily and for the first part of the game were on the defence. The forwards were outplayed by the heavier Blackheath pack and the three-quarters were outpaced by their opposite numbers. It was not long before a defensive misunderstanding on the blind side led to a try for Blackheath. Within a few minutes D. Parker kicked a drop goal for Blackheath. At this point the Guy's forwards rallied and carried the game to their opponents 25. Here D. le Clus kicked a penalty goal.

After half-time the Guy's team played with more spirit and determination. C. T. M. Wilson and N. Malyon put in great work, both in the tight and loose. Blackheath scored another try to make the score 9—3 and things looked dismal. In a gallant last 20 minutes Guy's pulled the game out of the fire. They heeled the ball from loose and tight; the three-quarters ran well and soon E. Williams crossed for a try. The final score came when G. Bellis picked up a loose ball and hurled himself over the line.

The game gives cause for hope that something may come of the team this year. The spirit and rallying power are there but at the moment the scoring ability is lacking.

Guy's *v.* United Services Portsmouth

At Portsmouth. Won 14—6.
1st October, 1949.

Once again Guy's began sluggishly but warmed to their task more rapidly than is usual. Within two minutes D. le Clus kicked an excellent penalty goal from the 10 yard line. The struggle developed keenly after this, with United Services making most of the play and spoiling some grand passing movements by simply overdoing them. Guy's were lucky at this period to hold out. A number of penalty kicks were given, none of which were kicked. Finally, however, one for United Services brought the scores level. Then came the best attacking move of the match. Eksteen gathered a loose ball somewhere near his own 25 and ran across the field until he was in the open. Then, straightening up, he drew the wing and passed to Gray who ran half the length of the field to score behind the posts. The try was unconverted.

The Guy's forwards were good after half-time despite the fact that the pace was telling. The threequarters played a more co-ordinated game and defended well. D. le Clus, who gave a brilliant display at full-back, kicked a penalty goal. A good movement between Smith, Birch and Williams on the left-wing resulted in Williams scoring a try which was converted. The Services reduced the score with a try. Their numerous attempts at penalty goals could, if successful, have won them the game. Guy's team should remember; the penalties were all for mistakes that could easily have been avoided.

ASSOCIATION FOOTBALL

Guy's *v.* Kew

At Osterley. Drew 1—1.
24th September, 1949.

Guy's Hospital opened this Southern Amateur League programme with a visit to Kew Association. The Kew side started off as though they would overwhelm the Guy's defence, and only superb tackling by the rearguard prevented a score. After ten minutes Kew opened their account direct from a free kick taken from just outside the penalty area, awarded for an unneccessary foul by a Guy's defender.

This reversal proved a shot in the arm to the hospital side and the rest of the half saw both sides playing grand open football, but there was no further score.

After the interval Guy's dictated play for a long period and the scheming of Prince made many openings which were not put to maximum use by the other forwards. Guy's gradually lost territorial advantage and only a desperate fling by Fearn in goal prevented a further deficit to Guy's. With fifteen minutes of play to go, Sturdy scored the equaliser with a lob shot, his initial effort having been charged down. The final whistle came with both sides striving hard but unavailingly for the winning goal.

The play of the Hospital side in this, their first league game, augers well for the future, the main weakness being on the extreme wings where more determination and a better sense of positional play is essential, but these faults will probably rectify themselves as the team settles down.

Team: A. Fearn; D. Lipington, P. Holloway; D. Matthews, C. Leckie, A. Swift; B. Cornhill, E. Sturdy, D. Harris, A. Prince, D. Oldfield.

ASSOCIATION FOOTBALL

Guy's *v.* Martin's Bank

At H.O.P. Won 4—3.
Saturday, October 1st, 1949.

A fortnight previous to this match a Guy's "A" XI. had played Martin's Bank "A" XI. and won 7—0, and the ease of this victory had so percolated into the minds of the 1st XI. players that they opened the play in this match with an all too lazy attitude. Consequently, after an uninteresting half, the Hospital side was 2—1 down and immediately on the resumption they were two goals in arrears through a charge that was in doubtful taste, on the home goalkeeper as he was attempting to intercept a centre.

At this point the home side started to play fast clever football and a hard shot by Oldfield found the net via the goalkeeper's arm. Then a solo dribble by Prince levelled the scores and ten minutes from the end Harris showing a nice turn of speed to beat the custodian in a race for the ball and placed it accurately in the goal.

In the home team only Prince and Lipington enhanced their reputations, though two newcomers to the side, Willcocks and Southgate, played very creditably, and will improve even more with familiarity with their positions on the field.

Team: A. Fearn; D. Lipington, P. Holloway; D. Matthews, A. Southgate, A. Swift; B. Cornhill, J. Willcocks, D. Harris, A. Prince, D. Oldfield.

GOLF

Beveridge Cup—2nd Round

Guy's *v.* St. Thomas's

At Royal Blackheath G.C. Won 3½—2½.
21st September, 1949.
(Guy's names first)

I. R. Caldwell beat H. E. Webb, 4—3.
J. M. D. Grant halved with D. G. A. Leggett.
J. K. Anderson beat T. G. K. Marr, 7—5.
R. Pook lost to Shuttleworth, 1 hole.
M. J. Quelch lost to P. I. Forbes, 5—4.
J. A. Mepsted beat R. T. D. Fitzgerald, 4—3.

Final against St. Bartholomew's Hospital on 19th October, 1949.

Guy's Diary

ACADEMIC

October

		Exhibition. Medical and Dermatology Departments. "Addison's Contribution to Medicine." Gordon Museum.
		Exhibition. Surgical Department. "Chronic Gastric and Duodenal Ulcer."
10th.	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
12th.	4.45.	Guy's Science Club. Dr. A. F. Hughes. "The Study of Living Cells" (with film illustrations). Staff Common Room. (Tea 4.30).
13th.	4.30.	X-ray Demonstration. Gordon Museum.
14th.	1.00.	Dr. A. C. Hampson. Clinical Lecture.
	2.15.	Medical Department. Combined Round. Preclinical Classroom.
17th.	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
18th.	12.00.	Medical Department. Neurological Demonstration. Preclinical Classroom.
20th.	4.30.	X-ray Demonstration. Gordon Museum.
21st.	1.00.	Dr. J. M. H. Campbell. Clinical Lecture. "Prognosis."
	2.15.	Medical Department. Combined Round. Preclinical Classroom.
	5.00.	Medical Department. Junior Staff Discussion. Preclinical Classroom.
24th.	1.00.	Dr. Forman. Clinical Lecture.
	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

OTHER ENGAGEMENTS

15th.		Rugby XV. *v.* Bedford. (H.O.P.).
		Hockey 1st XI. *v.* Romford. (Away).
		Hockey 2nd XI. *v.* Romford. (H.O.P.).
		Hockey 3rd XI. *v.* Romford. (Motspur Park).
18th.	1.15.	St. Luke's Day Service. Southwark Cathedral.
22nd.		Rugby XV. *v.* Plymouth Albion. (Plymouth).
		Hockey 1st XI. *v.* Barclays Bank. (Away).
		Hockey 2nd XI. *v.* Barclays Bank. (H.O.P.).
		Hockey 3rd XI. *v.* Barclays Bank (Away).
24th.		Rugby XV. *v.* Paignton. (Paignton).

Hospital Information, etc.

NOTICES

ST. LUKE'S DAY SERVICE

A special service for doctors, nurses and all engaged in hospital or public health work, will be held in Southwark Cathedral on St. Luke's Day, **Tuesday, October 18th, at 1.15 p.m.** (ending before 2 p.m.). The address will be given by The Revd. Canon Marcus Knight, B.D., Precentor of St. Paul's Cathedral.

It is fitting that such a service should be held on this day, as St. Luke is described in the New Testament as the "beloved physician."

Medical, nursing and other representatives from hospitals and health services in this part of South London are being invited to attend. We trust that it will be fully supported and attended by all past and present members from every department of Guy's.

H. E. ASHDOWN,
Provost of Southwark.

8th October, 1949.

UNIVERSITY OF LONDON

Ph.D.

FACULTY OF MEDICINE (NON-CLINICAL).

J. Naylor Hunt

PASS LIST
CONJOINT BOARD

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September, 1949.

Anatomy.

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R. M. Saldanha
A. Trenhaile

Physiology.

C. O. Bedell
M. F. Gill

Pharmacology.

A. C. Abdool-Raman
R. K. Allday
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ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

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J. C. J. Sheppard
G. K. Taylor
D. W. Thomas
C. J. Walker
D. E. M. Warner
G. F. Willcox
A. E. Woods

APPOINTMENTS

A. C. C. Hughes, M.R.C.P., appointed Chest Physician, Chester Area.

H. Douglas Lamb appointed Assistant Professor of Psychiatry to the University of Minnesota.

PAPERS BY GUY'S MEN

Craft, A. W. J. Amputations, Limb fitting and Artificial Limbs. *Ann. Roy. Coll. Surg. Eng.*, 1949, **5**, 190.

Levin, B., and Another. Oral Penicillin in the Newborn. *Arch. Dis. Child.*, 1949, **24**, 171.

Ogilvie, Sir Heneage. The Use of Experience. *Brit. Med. J.*, 1949, ii, 663.

Rushton, M. A. Two histological Abnormalities. *Brit. Dent. J.*, 1949, **87**, 142.

Southwell, N. The Treatment of Hay Fever. *Brit. Encycl. Med. Pract.*, Interim Suppl. 84 (Sept., 1947), p. 3.

Witts, L. J., and Another. Chronic Agranulocytosis. *Quart. J. Med.*, 1949, **18**, 173.

CHANGES OF ADDRESS

H. Douglas Lamb, University of Minnesota (Students' Health Service), Minneapolis 14, Minn., U.S.A.

W. Hopkin-Jones, M.R.C.S., L.D.S., 22, Harley Street, W.1. (Tel. Langham 5221.)

J. W. Graves-Morris, M.R.C.S., L.R.C.P., Fairfield, Sampford, Peverell, nr. Tiverton, Devon. (Tel. Sampford Peverell 307.)

D. N. Leeming, M.R.C.P., Westcliffe House, 1a, Westcliffe Road, Southport. (Tel. Southport 66529.)

G. R. Wotton, M.R.C.S., L.R.C.P., 18, Johnston Walk, Tilehouse Estate, Stoughton, Guildford. (Tel. Worplesdon 171.)

BIRTHS

COUPER.—On September 8th, 1949, at Bromley, Kent, to Mary (née Walsh), wife of E. H. Couper, M.B., B.S.—a daughter (Rosalind Catherine Mary).

HAWKINS.—On September 30th, 1949, at the Queen Elizabeth Hospital, Birmingham, to Susan (née Fantes), wife of Dr. Clifford Hawkins—a sister for Michael John.

SICHEL.—On September 5th, 1949, at Welford, near Rugby, to Betty (née Lawson), wife of Dr. G. R. McK. Sichel—the gift of a daughter (Ruth Marjorie), a sister for Barbara Ann and Jennifer.

MARRIAGES

BROWN—EMSLIE.—On 8th January, 1949, at Ross Memorial Church, Perth, W. Australia, Alec H. Brown to Marjorie Emslie, S.R.N.

ORGAN—DAVIS.—On August 20th, 1949, at St. Andrew's Cathedral, Singapore, Charles Desmond Organ to Monica Cecilia Davis.

DEATHS

MACRAE-GIBSON.—On September 26th, 1949, in Guy's Hospital, John Hume Macrae-Gibson of Highworth, 36, Brockley Park, S.E., aged 67 years.

BENTLEY.—On September 26th, 1949, in the Wilson Hospital, Mitcham, Harold Bentley, M.R.C.S., L.R.C.P., of 380, London Road, Mitcham.

Eds. {R.G. P.A.Z.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol LXIII *No.* 1598 *22nd October 1949* *Ninepence*

PASSIM

IF you observe a good craftsman at work you will probably notice that from time to time he stops and perhaps stands back from his work to cast a critical eye on what he is making. We should suppose that in Medicine, too, there is the same need to review one's work critically; but if in Medicine the need is the same as in other crafts its fulfilment is much more difficult. There are two reasons for this. Medicine is such an all consuming subject that it is difficult, especially for G.P.'s, to stand very far back from it. Secondly, people who work with their brains prefer to relax either by doing something which requires no particular mental effort (though perhaps much physical effort) or by turning their minds to other subjects—collecting, reading, listening to music, etc. Relaxation of some sort or another is of course just as essential to the doctor as to other people; but it is essential, too, for Medicine that doctors should reflect critically upon their own work and, in our view, the doctor needs outside help in order to be able to do so.

Perhaps one of the greatest aids to learning and reflection which a big hospital provides is in its "critical atmosphere," that atmosphere, to put it bluntly, in which there is a premium on intellectual honesty and a discount on "bull." Guy's provides a great deal more than atmosphere and we are wondering whether it might not be possible for Old Guy's Men as well as the present generation to take advantage of it. What we are wondering, in fact, is whether it might not be possible, once a year, to have a week at the Hospital devoted to all Old Guy's Men, especially G.P.'s. This week would not be primarily a reunion, though of course it would be that amongst other things, it would not be a postgraduate course, nor yet a conference, but just a week, once a year, in which all arrangements were made so that Old Guy's Men might perhaps come back and see us. A week when all the Departments, Staff and Students might especially put themselves at their disposal. A week, in fact, which might be of great value in enabling these Guy's G.P.'s to turn over in their own minds their ordinary day to day work.

We doubt if many doctors have a feeling for their old Hospital as strong as do Old Guy's Men for Guy's, and we feel that many of them might be drawn back to their own hospital when they might avoid a set conference or course of instruction. Such a gathering, we feel, might be of great value to them. And if a week of this kind were of value to them, how valuable and enjoyable it would be, too, to us to have such a strong gust of fresh air blowing into the Hospital once a year. Such an influx of practical men might well bump us back to earth on many occasions and their presence might do more than anything else to bridge the gap between Hospital and General Practice, to preserve the Guy's tradition and to bring together Guy's Men, old and new.

Note Book

Bon voyage.

Mr. Brock and Mr. Blaikley both left this country, last week for the United States. We wish them both a very successful trip and a safe return.

Congratulations.

Congratulations to A. C. de B. Ecksteen, D. le Clus, C. T. M. Wilson and W. G. Davies on being selected for the United Hospitals Rugger Team which travelled to Paris on October 9th and beat Paris University 10—9.

Thatchings.

It is interesting to note that this delightful Rest Home at Bognor has never been empty of guests since its opening 18 months ago, except for the Housekeeper's holiday last January. Whereas the authorities only expected a handful of guests chiefly during the summer months, " Thatchings " has been completely booked more often than not and is open the whole year round. Congratulations and thanks to Mr. and Mrs. Lewis for the great success they have made of their job !

Curious.

We read the following paragraph in the *South London Press* last week : " Colleagues of an Ear Specialist at a South London Hospital decided to make a presentation to him on his retirement. They gave him a silver salver in the shape of an ear. At the farewell party he thanked them and said he had spent many happy years in their company. He added, " I wonder what you would have given me if I had been a Gynæcologist ! "

A Case of Complete Heart-Block During an Initial Attack of Rheumatic Fever

By J. H. KERR.

ALTHOUGH degrees of heart-block are commonly to be found in cases of acute rheumatic fever, complete heart-block is rare. Campbell reported one case in 1931 and Wedd, in America, two such cases, one in 1932 and the other in 1937; since then there have been a few isolated reports. This case is unusual, therefore, in that a brief period of complete heart-block occurred during the patient's first known attack of acute rheumatic fever; there were also attacks of paroxysmal tachycardia a few days after the termination of the heart-block.

Case Report.

The patient presented himself on the evening of 5th April, 1949, and complained of a general malaise of two weeks standing and of pains in the knees which had begun one day previously.

He was a well-built individual, aged 17 years, employed as a plumber's mate, and living at home with his family who, with one exception, were all well. One sister had suffered from rheumatic fever some twelve years previously, at the age of seven, and had since been the subject of " heart disease." The patient had no complaints to make about his living conditions, but did disclose that the room in which he had slept during the last six years had damp walls. Of the usual childhood diseases, he had contracted measles, whooping cough and mumps, but not scarlet fever, chorea or any previous attack of rheumatic fever, nor had he had diphtheria. Three years before, he had a spasmodic valgus of the left ankle, and whilst in hospital for manipulation of the ankle, he had his tonsils removed. One week prior to the commencement of his present complaint, he had experienced a sore throat.

Day 1. The present complaint, according to the patient, began two weeks before admission to hospital. He began to feel unwell and had bouts of perspiring and shivering. Also during this time he had several attacks of " palpitations " whilst playing football. The bouts of perspiring and shivering had occurred from time to time, but the malaise had been continuous.

Day 13. One day prior to admission, on getting out of bed and putting his weight on his legs, he experienced a sharp pain in both knees which died down to a constant ache when he moved them about. The pains got worse as the day progressed, but he found he could relieve them by resting his legs.

Day 14. *Admission.* The pains occurred in the same sequence on the day of admission, but by the time he came to hospital they were extremely severe. Additional stiffness in the elbows was now present. He had sustained no recent injuries.

He was flushed and had a temperature of 101.4° F. His pulse was regular at 75, and his blood pressure was 120/85. His apex beat, in the fourth left interspace in the mid-clavicular line, was forceful, the second sound in the pulmonary area was accentuated, and a systolic murmur was heard over the mitral area. He had pains in the knees on movement and stiffness in the elbows. There were no other abnormal findings.

Day 15. The next morning, ten hours after admission, the patient felt much better, but he had injected fauces and a tender neck; glands were palpable in both groins and axillæ and in both epitrochlear regions. The pulse was irregular, and over the apex beat a reduplicated first sound was heard. His E.S.R. was 35 mm. in the first hour; his hæmoglobin was 85 per cent. (13.26 gms. per cent.); white cell count 6,100; polymorphonuclears 31 per cent., eosinophils 4 per cent., basophils 0 per cent., lymphocytes 53 per cent., and monocytes 11 per cent.; a Paul Bunnell test was negative.

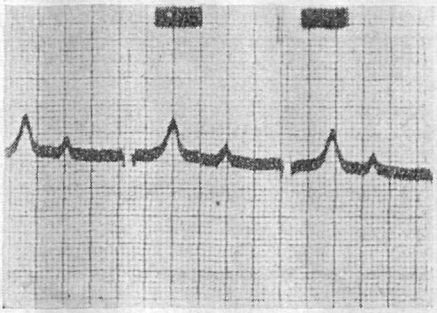

Fig. I.
E.C.G. taken at 1.00 p.m. on day 16 showing the partial heart block.

Day 16. On 7th April, the heart sounds were normal and the pulse was regular, but E.C.G. showed changes in the heart. One, taken at 1.00 p.m., showed 1st degree heart-block producing a very long P–R interval of 0.46 seconds. At times there was complete heart-block. Another, taken at 6.00 p.m., showed continuous complete heart-block, with a ventricular rate of 58 and a very irregular auricular rate of about 40, due, possibly, to sinus arrhythmia. His E.S.R. was 47 mm. in the first hour.

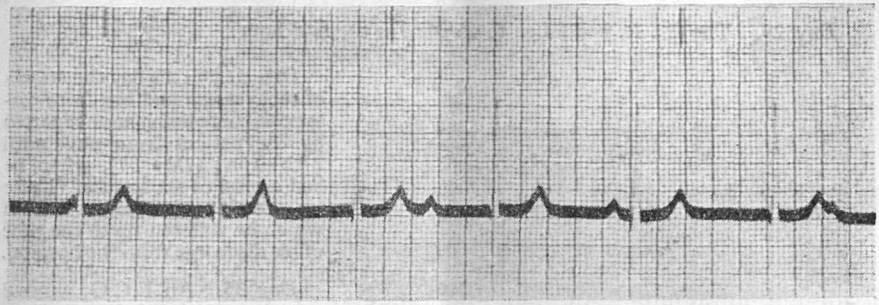

Fig. II.
E.C.G. taken at 6.00 p.m. on day 16, showing the complete heart block.

Day 17. His pulse was regular and a systolic murmur was again heard at the apex; an E.C.G. showed that the complete heart-block remained. The ventricular rate was 56 per minute, and the auricular rate was now about that of the ventricles, and considerable sinus arrhythmia was still present. Salicylate therapy (Mist.Sod.Sal. grs. xxx 4-hourly) was commenced.

Day 18. The ventricular beat showed periodic spasms of irregularity.

Day 19. The pulse rate showed a tendency to drop and an E.C.G. the next day, when the pulse had again become regular, showed that sinus rhythm had returned. Considerable sinus arrhythmia was present, with the heart rate varying from 46 to 65 per minute. The P–R interval was 0.24 seconds.

Day 22. The patient reported two attacks of palpitations; he described these as a feeling of acceleration of the heart which commenced suddenly, lasted a minute or two, and terminated abruptly.

Day 23. The next day the heart was palpated and the beats, before, during and after one of the attacks, were found to be regular. The attacks were occurring more frequently now, any movement made by the patient tending to produce one. The rate during the accelerated phase was counted and found to be roughly 124. An E.C.G. showed a sinus rhythm of about 50, and a P–R interval of 0.18 seconds.

Day 28. These attacks were occurring every 30 seconds and lasting half a minute. An E.C.G. showed that the tachycardia started with a few irregular beats, after which it remained regular, until it finished suddenly; it was of a superventricular type of a rate of about 160. The P–R interval was 0.16 seconds.

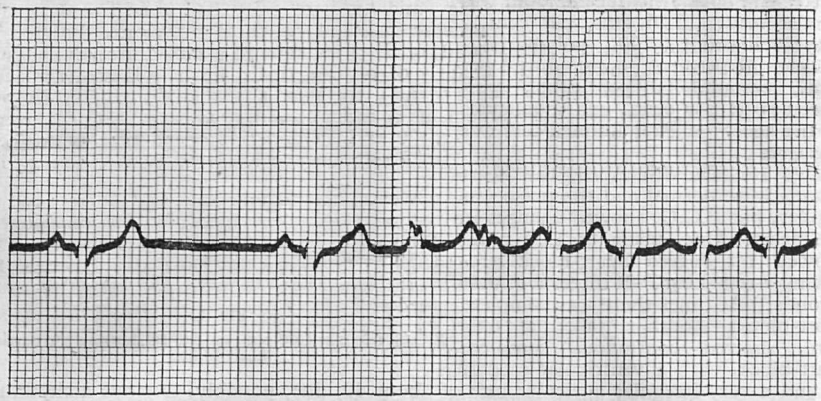

Fig. III. Part I.

Day 29. The E.S.R. had fallen to 15 mm. in the first hour.

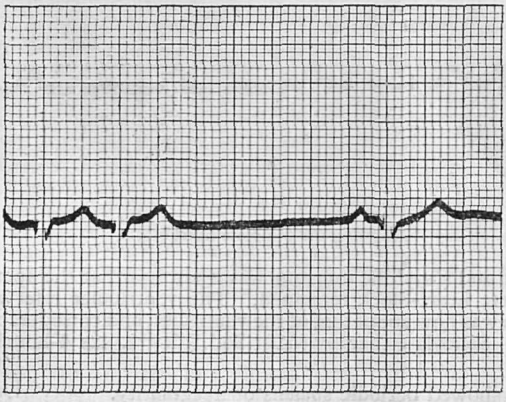

Fig. III. Part II.

Parts of the E.C.G. taken on day 28 showing the onset and the finish of an attack of Tachycardia.

Day 31. This day the attacks of tachycardia had begun to disappear, there being none reported by the patient from now until 27th April (*Day* 37), when he had a total of six attacks. These six attacks were the last from which he suffered up to the time of his discharge from the hospital.

Day 35. An E.C.G. showed no change since the previous one, except that there was a further diminution of the P–R interval, which was 0.14 seconds. The blood picture now showed a hæmoglobin of 83 per cent. (12.95 gms. per cent.), white cell count of 7,000, polymorphonuclears 57 per cent., eosinophils 1 per cent., basophils 0 per cent., lymphocytes 41 per cent., monocytes 1 per cent.

Day 43. A rash appeared on the patient's arms and legs which was extremely irritant. The E.S.R. was now 15 mm. in the first hour.

Day 44. The salicylate therapy was discontinued as the rash had become considerably worse. Calcium aspirin was now given grs. x b.d.s., and Anthisan mgms. 100 t.d.s. was administered until the rash had ceased to be irritant.

Day 51. The E.S.R. was 7 mm. in the first hour.

Day 57. An E.C.G. showed no change since the one of *Day* 35.

Day 71. (1) The patient was discharged to a convalescent home.

Throughout his hospitalisation the patient felt well continuously, with the exception of two brief headaches ; he was kept at rest, but for some slight occupational therapy, and left the hospital never having been out of bed. His blood pressure throughout remained between 130–70 mms.Hg., and his joint pains had gone five days after admission (*Day* 20). Throat swabs were cultured on three occasions, the first on *Day* 15, showed no growth ; the second, on *Day* 16, showed a mixed growth and subculture produced a growth predominantly of N. catarrhalis, no beta-hæmolytic streptococci or staphylococcus aureus being found ; the third throat swab, on *Day* 18, produced no K.L.B. on serum. No organisms or other abnormal findings were discovered in the urine. Blood was taken on *Day* 20 and an antistreptolysin titre performed ; this gave a value of 160 units per 1 cc. His Wasserman and Kahn reactions were negative.

On returning from four weeks convalescence, the patient appeared fit and had no symptoms. His pulse was regular and the position of the apex beat was unchanged ; the systolic murmur at the apex persisted but was not so harsh, and a reduplicated second sound was heard in the pulmonary area. The blood picture showed only negligible alterations and the E.S.R. read 6 mms. in the first hour. An E.C.G. was as that of a normal heart. A Schick Test was performed and gave a negative result.

All illustrations are taken from lead II of the electrocardiograms.

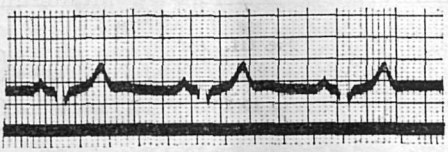

Fig. IV.

E.C.G. taken after return from convalescence showing the "normal" tracing.

I wish to thank Sir John Conybeare and Dr. Maurice Campbell for affording me the opportunity to record this case, and I should like to impress my appreciation to all those who have assisted me.

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Wedd, A. M. *Amer. Heart Jour.*, 1937, xiv, 759.
Wedd, A. M. *Clifton Med. Bull.*, **18**, 63, 1932.

Guy's Hospital Nursing School

THE annual function of the presentation of Prizes and Medals was held on Thursday September 29th. Tea was served in the Nuffield Nurses' Home at 4 p.m. to a large number of visitors who were received by Lord Cunliffe and Matron. It was a great pleasure to welcome so many parents, headmistresses, matrons, members of the staff and their wives, and members of the Hospital Board. The gathering of colleagues and friends over a delicious tea was an admirable preliminary to the great event of the day.

The Physiology Theatre kindly lent by Professor Spurrell was filled to overflowing. Lord Cunliffe, Chairman of the Hospital, presided and in welcoming the visitors said how pleased he was that the Nurses' Prize-Giving had been established as an annual academic event. He extended a warm welcome to Lord Moran who spared us some of his valuable time to present the prizes. Lord Cunliffe then asked the Sister Tutors to report on the year's work in the Nursing School.

Matron added her welcome to the Chairman's and told the audience that we now have student nurses from many different countries, and that Guy's trained nurses were working all over the world. She welcomed the new link with the Evelina Hospital for Sick Children and said that the Matron and Sister Tutor there were now members of the Education Committee of the Nursing School.

Mr. Doherty, the Superintendent, added his welcome to Lord Moran and the visitors and told the audience and the nurses in particular how much work was being done on their behalf behind the scenes, and how important it is in these days of nationalisation to preserve tradition and individuality. "We want our nurses to be Guy's nurses, not merely people who are nurses."

Lord Moran then presented the prizes to the nurses :—

Pharmacology	1st Prize	J. I. Lewis R. J. Payne N. Thompson
	2nd Prize	E. Scotchmer G. Warner A. Calderwood
Surgery and Surgical Nursing	1st Prize	F. G. Ward E. C. Perry J. Clarkson M. Wendes
	2nd Prize	G. Warner J. Burbridge J. Finlay
Medicine and Medical Nursing	1st Prize	J. Mitchiner K. Faber P. Webb
	2nd Prize	G. McGuinness J. Biggs D. Cooper
Speiael Diseases	1st Prize	M. Fraser G. Rosenau D. Bicknell
	2nd Prize	A. Stewart K. Faber V. Appleton M. Maxwell
Guy's Final Examination	1st Prize	M. Pepper P. J. Booth J. Greatorex M. Fraser
	2nd Prize	J. Thorpe M. Atkinson

Medals.—Awarded to the Nurses obtaining the highest aggregate number of marks in all the Examinations and taking into account their record of practical work.

Cazenove	Gold Medal	M. Walker
	Silver Medal	B. Warne
	Bronze Medal	B. Woodward

Butterworth Medals.—Awarded after seven years' consecutive service to :—
Lucy Puddifoot
Ada Long
Marion Leates

Lord Moran then gave his address. We were privileged to hear a little of the lighter side of his life during the war with Mr. Churchill. He emphasised the importance of observation in a nurse, "seeing something which others do not see," and the importance of tolerance in the post War World. Lord Moran talked of the use of leisure and how essential it is to be able to escape from responsibilities and anxiety, the realms of literature and hobbies provide wonderful opportunities.

A vote of thanks was proposed by Nurse Pepper and seconded by Nurse Fraser to Lord Moran and Lord Cunliffe.

F.T.

Practical Anatomy. By W. E. Le Gros Clark. 2nd Edn. Edward Arnold. *Price* 30*s*.

In the present edition of this book there is a considerable improvement on the previous edition, especially in illustrations.

Some coloured illustrations, such as those on pp. 362 and 368, are still poor.

The Portal Vein, pp. 420 and 421, has its main description on p. 431. Even this is brief when compared with the importance of the structure, its tributaries and relations.

Nevertheless this book, as a practical guide to dissection, and used in conjunction with a standard textbook, can be recommended to the student.

I.D.H.

Also received—

German-English Dictionary. By F. S. Schoenewald. H. K. Lewis. *Price* 27*s*. 6*d*.

National Health Service. By Charles Hill and John Woodcock. Christopher Johnson. *Price* 16*s*.

Guy's Hospital Reports, Vol. 97, Nos. 3 and 4, 1948.

The New Guy's

BY order of the Governors of the Hospital a meeting was convened in the Medical School on Tuesday, 11th October, at which those interested in the development of the New Guy's were invited to be present, to be given an account of the history of the project, the present official policy, and to voice any criticisms or suggestions.

Lord Cunliffe, who took the Chair, opened the meeting by explaining that prior to the outbreak of war, the Court of Governors came to the conclusion that the establishment of a thousand-bed hospital was essential for adequate undergraduate teaching. At that time the renovation and repair of Guy's Hospital was regarded as possible and plans for blending old and new were considered but not regarded as satisfactory.

Mr. Lees Read, Clerk to the Governors, next surveyed the progress of events during the war. In September, 1940, the first major damage was sustained and in April, 1941, the East Wing bordering on the Front Quadrangle was destroyed. The Court of Governors thereupon directed the Clerk to purchase as much as possible of the adjoining land and ultimately almost the whole of the site bounded by St. Thomas's Street, Weston Street and Snowsfields, an area of approximately nine acres in extent was acquired.

A Post-War Planning Committee was set up in February, 1942, being a joint body of the Hospital and Medical School. During two years' work a series of reports was prepared and Mr. Alner W. Hall, F.R.I.B.A., was officially invited to prepare schemes in conformity with the suggestions therein and without stipulation as to retention of any of the old building as at this time the repair of the badly damaged and partly destroyed Guy's House was regarded as too costly and uneconomic to be worth serious consideration.

At this stage, Mr. Hall himself addressed the meeting and presented a resume of the work he had undertaken. To begin with a decision had to be made as to the proportion of the site to be used. Then the first idea was to plan a new Surgical Block in place of Guy's House and, in this connection, as Architect, he was given a reasonably free hand. The possibility of including a Medical Block in the new project was next mooted. A scheme for entirely new Surgical and Medical Units with a new College and new Dental Hospital and School was drawn up, due regard being paid to the effects of the new County of London Plan on the layout of the neighbourhood and its streets. At this juncture, namely five years ago, a general meeting was called at the Hospital and a full explanation was given to all those able to attend. Articles on the subject also appeared in the *Gazette* on 16th September, 1944. Subsequently the London County Council was approached but they raised various objections, pointing out that the County of London Plan itself was, as yet, by no means a reality.

A second plan was accordingly formulated in accordance with existing streets but this proved unsuitable in the light of proposals for the widening of St. Thomas's and Weston Streets.

Ultimately a third plan was prepared embodying in one building all the essentials of a great modern teaching hospital, the whole design radiating around a central tower. Economy of layout and efficiency of operation were the prime considerations and account was taken of the modified street plans for the district. Details of the new scheme were sent to the London County Council where they were under consideration for ten months before being passed to the Ministry of Health. Both authorities commented on the magnificent conception of the scheme.

In its relation to the existing hospital buildings, five units of the new centre could be developed without impinging upon the present site and the remaining units could be added at a convenient time later.

As Mr. Hall emphasised, the paramount difficulty is to blend tradition with functional efficiency. In the new hospital many of the principles employed in the Caroline and Southern Hospitals of Stockholm have been incorporated together to a modest extent with the height of the American hospitals and the assistance of Mr. Paul G. Burt, a distinguished American architect and the designer of the Wesley Hospital, Chicago, is being sought. No one denies the desirability of creating a new Guy's which will afford all the structural and material resources required for an efficient medical centre. Obviously such of the existing buildings as are useful should be preserved but, unfortunately, so many of them are now extremely unsound both in construction and in arrangement.

Invited by the Chairman to read from various letters received, Mr. Lees Read revealed that the Medical Committee on 6th October unanimously agreed to recommend the Governors to reconsider the possibility of devising a plan which will allow the retention and reconstruction of Guy's House for the sake of its tradition and architectural merit. Dr. Mann, unable to be present at this meeting, had written in a like vein, while Mr. R. C. Brock had expressed similar opinions.

Dr. Boland, Dean of the Medical School, who next spoke put in a very forceful plea for what he called " giving Guy's House a new deal." " It had," he said, " been totally excluded from the new plan but if restoration is possible (and we are not satisfied it is not) then let it be considered and the reconsideration of the proposals asked for by the Ministry of Health provides the opportunity for this to be done. If reconstruction is possible, it could probably provide accommodation for 250 beds or at least for administrative offices."

Dr. Campbell admitted that when the new plans were first published and a model (on show at the present meeting) first displayed they afforded much promise and attraction. On the other hand, now that there was pause for reconsideration, he strongly urged that a further attempt should be made to combine the new with the old and cited the Massachusetts General Hospital as a supreme example of the manner in which this could be achieved. He, therefore, proposed that the Governors should be asked to issue further instructions to the Architect to ascertain whether the present plans could be modified to leave Guy's House untouched.

Subsequent speakers insisted that the whole question revolved around the practicability or otherwise of renovating Guy's House. As Mr. Slesinger observed, it was the, Ministry of Health that had decreed the figure of 800 beds as maximum capacity, intimating at the same time that the whole scheme might be modified towards a more collegiate layout. But, as Lord Cunliffe noted in reply, the collegiate idea was most probably the view of one man rather than the Ministry as a body, and he thought there would be very few official objections to proceeding with the present scheme as far as the various authorities were concerned.

Clearly, no doubt existed at the meeting as to the wisdom of creating an entirely new Hospital which, based on modern principles and conceptions, would make effective use of the available space and simultaneously be efficient and economic in its working. The question was whether this could be achieved under the circumstances with the retention and preservation of the valuable and traditional parts of the present structure. Lord Cunliffe felt that as so many of the Governors had been present at the meeting and, in particular, the Chairman of the Planning Committee, no formal resolution need be moved. He was sure that the Board would give earnest consideration to the various opinions so strongly voiced and would most probably obtain other technical advice before proceeding with the design and construction of any new buildings that might entail the discarding of so much that was traditionally and sentimentally revered in the old.

Footnote.—Mr. Lees Read, Clerk to the Governors, reports that at the Meeting of the Hospital Planning Committee held immediately after the open meeting the following resolution was approved :—

> To recommend to the Board that the Chairman of the Planning Committee should obtain an opinion from an independent expert on the feasibility of preserving and, where necessary, rebuilding Guy's House so as to provide accommodation for in-patients as at present or, alternatively, for use as administrative offices, a college for the resident medical staff or for a Dental School ; and if, in the opinion of the expert, it was considered feasible to preserve Guy's House for any of these purposes then to obtain an approximate estimate of the cost of such restoration and preservation. It was, further, agreed to recommend to the Board that no further action on the plans for the rebuilding of the Hospital should be taken until the above advice was obtained.

Short Manual of Regional Anatomy. By J. A. KEEN. 2nd Edn. Longmans. *Price* 10*s.* 6*d.*

The second edition of this useful work is intended by the author to be a short revision of regional anatomy, and is written in note form, with an introduction, and sections on each region, including the central nervous system. 75 excellent simple diagrams are included. More space might profitably have been devoted to matters as important as lymph drainage of the breast. This book should not replace the synopses at present used at Guy's for revision purposes. P.L.

Student Exchange, 1949

IT is not without trepidation that this report is written. So much has happened in the past three months that it is difficult to the point of impossibility to do credit in words to so much incident.

The three months extended from June the 13th, when we landed in New York, until September the 14th, when we embarked for England, and during that time we covered a lot of ground—and not only metaphorically. We split at the beginning into two groups. Ian Thomas did surgery, and the writer stayed on the medical side of things, so this account will take into consideration only that part of American practice that was witnessed, namely, the medical wards and teaching.

Two months were spent at Yale in the New Haven Hospital, where I had a clerkship, three weeks at Billings Hospital in Chicago, and one regrettably short week at the Massachusetts General Hospital in Boston.

Work starts very early in America and it is not uncommon for some ward rounds to begin at 8 a.m., which really amazed us after our 10.30 a.m. experiences at Guy's. The wards are open 24 hours of the day, which, although excellent from the student's point of view, is hard on the patients, who resent intrusions on their privacy. The American medical student is without doubt much harder worked than his English counterpart, as the laboratory work done is so much greater in quantity. On the other hand, his practical experiences in manœuvres such as lumbar punctures are equally greater, so that at the end of two years a man will be familiar with, and competent at these procedures. The New Haven Hospital is not as large as Guy's, and is not in any sense a "voluntary hospital." Patients in the general wards pay $7 a day for hospitalisation alone, while private patients are charged $11 a day. When one takes into account doctors' fees and costs of special tests, it is easy to see that being ill is an expensive business. There is a form of insurance by which expenses are paid by a Society, but this "Blue Cross," as it is called, is operative only for the first three weeks in hospital, and many medical patients are in for longer periods than this.

Ward rounds are made every day but are not like the Registrars' rounds at Guy's, where cases are actively taught on solely for the benefit of the student. Here the rounds are precisely what they are by definition; a round is made of the ward and every patient is seen and discussed by the physician, with as much teaching as the latter cares to give. Thus, as at home, different rounds vary a lot depending on who is making them. As regards equipment and technique, American methods do not vary significantly from our own in the actual examination, except in blood counting. Here a word must be said about the hemocytometers in current use in the United States as compared with our own Burker Chamber. The instrument used is made by Spencer and is in every way superior to our own. The chamber is easy to find, there are two chambers on each slide, and the lines are ruled in such a manner as to make counting a much easier technique than it is when using the Burker Chamber. This really impressed us after the time spent at Guy's straining to find the cross lines on the Burker Chamber.

Biochemistry does not end at the door of the Biochemistry laboratory. If anything, it is emphasised more on the wards than ever. This fact was brought home on one of the first rounds, when the physician ordered blood potassiums, sodiums, and serum iodines. This method of "chemical medicine" is not without pitfalls, as a student at Yale in his final year, who knew immediately the normal value for the serum amylase, was unable to define Murphy's sign of cholecystitis. But to be fair to the New Haven Hospital, it must be remembered that it is primarily interested in research and that, with Dr. Peters at the head of its Metabolism Service, much fine work has been accomplished in the diseases of metabolism, particularly diabetes mellitus.

Boston is an extremely pleasant city east of New Haven. It is a medical centre, with names like Paul White, Levine, Meigs, and Fuller Albright to make it so. We stayed a week at the Massachusetts General Hospital and were much impressed by its size and efficiency. In the old Bulfinch Building we were taken with reverence to the "Ether Dome," where on that fateful day over a hundred years ago anæsthesia was first demonstrated. It was very thrilling.

It was while here that we learned the latest information concerning Compound E in its relation to rheumatoid arthritis. The results are disappointing because (*a*) patients who leave off therapy immediately relapse, and (*b*) those cases that have had continuous therapy with Compound E develop Cushing's Syndrome. However, new and allied compounds are being sought, and Hench's work is looked upon with great esteem.

It was at the Massachusetts General Hospital too that I met David Stafford-Clark, who is working there in the Department of Psychological Medicine. To meet another Guy's man so far from the Borough was a most pleasant surprise. Incidentally, concerning Guy's, the name of our hospital stands very high in the United States. It is often the only English hospital people have heard of and is looked on with great respect.

After this week's sojourn in Boston, perhaps the most English-looking of all American cities, I left by car for Chicago. The journey there was most enjoyable since we stayed over night at Niagara Falls and then went up through Canada to avoid the masses of cars at Detroit. So much has been said before of Niagara that a description of the mighty cataract from a medical student would be redundant. Suffice it to say that whatever has been written about the Falls is true. They are magnificent. The Great Lakes too are incredible. To see apparent seas with waves tossing large ships about and then to realise that the water is fresh is an extraordinary experience.

Chicago is a city of some 4,000,000 people, the second city of the United States. It is a city of contrasts, as will be brought out later, and contains some beautiful lakeside boulevards and some of the worst slums in the world. I stayed for three weeks at the Billings Hospital, one of the University of Chicago clinics, large and up-to-date, having been built in 1926. It is Billings that I would like to take as typical of the medical schools in the United States, for, from what can be learned from students here, it is a pretty nice average. It is a large hospital but has only about 350 beds, the rest of the space being taken up for research. All kinds of work are carried on here, but mostly cancer research, which is much boosted on this side of the Atlantic. At Billings the Huggins Test for malignancy was devised. It is apparently 98 per cent. accurate and depends upon the fact that in malignant disease the heat coagulability of the blood proteins containing the —SH group is changed. Unfortunately it is also positive in cases of longstanding T.B.

The two clinical years at Billings are divided into the Juniors and Seniors. The Juniors work on the wards and spend four three-monthly periods in medicine, surgery, midwifery, and pediatrics. The Seniors spend their time in the clinics of the Outpatient Department and in general have an easier time than their colleagues, who are hard pressed with writing up patients and laboratory work. Rounds begin at 9 a.m. if there is an 8 a.m. lecture, and at 8 a.m. on days when there is no lecture. There is a noon clinical lecture very much like the Guy's clinical lectures, and then there are the afternoons, which vary from day to day. Some days they are "free"—free in the sense that nothing is organised, which gives the students time to catch up on their blood counts, etc. At other times there will be clinico-pathological meetings and X-ray conferences, when students, two at a time, are called upon to interpret current X-rays. This seems to be an excellent idea and is certainly popular at Billings. These meetings often continue until 7.30 p.m., and it can be said with truth that it is not unusual for a student who started work at 8 a.m. to be still in the hospital working at 1.30 a.m. the following morning. This may seem far-fetched, but is a common occurrence. The men and women really do have to work to keep up with their cases, and we at Guy's cannot appreciate just how hard they do work. Dragstedt is at Billings but apparently only seldom performs vagotomies, and then only on selected cases. Professor Carlson is the head of the Physiology Department and, although elderly, is still very much active. He was very courteous when we visited him and sent his regards to Professor Spurrel.

The physicians at Billings are unique in the United States in that they are full-time workers at the hospital. They are paid by the University of Chicago and are not allowed to indulge in any private practice. Any consultations they may give, bring in fees—to the hospital. This makes for good teaching, and at Billings the standards are very high in this respect, better than anywhere else that was visited. All subjects are taught at high pressure, with the students taking an active part and being made responsible for the care of their patients. In a cosmopolitan town like Chicago, they must be something of linguists if they are to enjoy rapport with their patients. Billings was so impressive that it would be an excellent plan if next year Guy's exchanges directly with them, taking two Billings students in return, for a period of three months. The Dean there was most enthusiastic about the project and has expressed his approval for plans to be made for the future. If too much praise has been given to Billings, let it be balanced with a little criticism. Their midwifery is really amazing, especially after Mr. Gibberd's teaching. Episiotomies are routine. Forceps are put on in all cases, and breeches are not turned. No comment! On seeing a delivery there one was impressed with the efficiency of Victoria Ward and how good the Minnitt apparatus is. "Saddle blocks," as local analgesia, are employed, thus depriving the mother of the bearing-down reflex

and necessitating the forceps delivery. Analgesia is not complete, and the method as a whole is not equal to our current practice. Incidentally, the left lateral position has been abandoned, and women are delivered in the lithotomy position, when leg cramps manifest themselves as a common complication.

Apart from these three hospitals, arrangements were made for us to see various institutions in Connecticut. We saw a state sanatorium, a state mental hospital, a hospital for children with rheumatic heart disease, and a home for the mentally deficient. All these places were built under the auspices of one Governor Cross, who evidently was a man of great integrity, since he instituted many such places in the state which have been successful in later years. The buildings were large, clean, and well run and were set in really beautiful New England countryside. The sanatorium in particular was worthy of note in that it is practically self-sufficient, having its own shops and farms so that it can carry on commerce with towns nearby.

Everywhere we went we were treated with great kindness and sympathy. The fabulous American hospitality is no myth, and one could not meet a kinder and more generous people. From the Deans downwards everyone made us feel at home and was most enthusiastic about the idea of a Student Exchange. The informality did nothing to cloak the really great affection the United States has for Great Britain, and most of the Profession is watching with interest the experiment of our Health Scheme. Guy's Hospital has a great reputation in America, and it is our opinion that, by furthering these exchanges at all levels, we can make Guy's more than a great name, and implant in our counterparts' hearts with respect to Guy's that affection which we have acquired for Yale and Chicago. Lastly, we would like to thank the Dean of Guy's, the Dean of the Yale Medical School, Guy's Hospital Students' Union, and the Association of Interns and Medical Students of America in particular for making this exchange the wonderful success that it has been. We earnestly hope that this is but the first of many such exchanges which will bring pleasure and profit to all.

B. H. BASS.

New Haven,
September, 1949.

My Visit to the U.S.A. 1949

By I. B. THOMAS.

IT should be made clear from the outset that it is difficult to give a clear view in this report of American medical education as our stay in New Haven and Philadelphia coincided with the summer term, so there was little routine teaching and the elective surgery was somewhat modified by the hot weather. There are two aspects of the trip which might be of interest—medical education in the States and our travels, so this report is split up into these two groups.

(i) *Medical Education in U.S.A.*

American medical education differs from our own in many respects. The degree taken is M.D. and the training is started after the student has spent 3–4 years in an undergraduate school and has taken his B.A. in " 1st M.B." subjects and the liberal arts. This training is divided into two periods. In the first two academic years courses are taken in the basic medical sciences. These include Anatomy, Physiology, and Physiological Chemistry in the 1st year and Bacteriology, Pathology and Pharmacology during the 2nd year, although this sequence of course is not obligatory.

In the 2nd period the student studies clinical medicine and public health and during this period one term is available for elective work. After graduating at the end of this course, there is, in most States, a compulsory Internship for one year which is the equivalent of our House Surgeon or House Physician's appointment.

The cost of this education is much greater than that paid by the student in Britain—the tuition fees being (before devaluation) about four times as great. This is offset to some extent by the fact that most students do non-medical work in summer and can earn enough money to pay their fees.

At Yale the plan of study seems designed to encourage the student to continue his studies after he has graduated so that he will specialise, teach or do research work and the curriculum allows students to develop their special interests and talents. Laboratories are available for people doing student research and they may spend more than the specified time on certain appointments if they wish.

There seems a sad lack of practical experience in certain courses such as anæsthetics which is disposed of in a period sometimes as short as two weeks. Obstetrics is covered in six weeks but it must be remembered that most normal deliveries are done by specialists.

The Out-patient work at New Haven is done as a separate appointment and therefore the patients are not often followed through to the wards, nor is there anything to correspond to our take-in weeks. In addition to the above course there is a scheme in Kansas City to spend three months with a G.P.

The year is divided into four terms. During the summer one, which is optional, a vacation is usually taken. When the student is at the hospital he works much harder than the average British student, starting at 8 a.m. and finishing when all his duties are completed. The wards are open all day and night and this displays the trend of American medicine with some people to attach more importance to the disease than to the patient.

The classes of students in New Haven are quite small and they enjoy individual attention. The relationship between Staff and Students was informal, but the discipline was very good. This informality is one lesson we can certainly learn.

The New Haven Hospital is a modern building containing about 600 beds. Each ward consists of about 12 single rooms and four 4-bedded wards. At one end of the ward is a solarium and at the other is the nurses' office, doctors' office and dressings room.

Yale Medical School is situated across the road from the Hospital and is a very well equipped building. The most desirable part of it is a magnificent air-conditioned library which is both comprehensive and efficient, remaining open until 10 p.m. from Monday to Friday.

(ii). *Our Work and Travels.*

Bass and I arrived in New York on June 13th and started work at Yale on June 16th. Bass spent most of his time on the medical side and I chose the surgical side.

I worked as a dresser with the head of the Department of Surgery, Prof. Lindskog, and with the Assistant, Prof. of Vascular Surgery, Dr. Glenn, and then for a time took the place of an intern under Dr. Taffel. The two residents over me had been in Britain during the war and they, in common with everyone else, did all they could to make me feel at home.

Each patient on entering the surgical side had a full history taken and was given a very thorough physical examination, even to the extent of examining their E.N. and T. Complete blood pictures were done by the dresser and blood taken for estimations of the N.P.N., serum proteins and serum chlorides, as a routine. In all abdominal cases the serum amylase was estimated.

The pre- and post-operative care of the patients was very impressive and there was earlier ambulation than is usual in this hospital, appendix cases often getting up within 24 hours. Extensive use was made of spinal anæsthesia and local anæsthesia was employed more frequently than at home, especially on hernias, etc. The main suture material used was silk and occasional use was made of wire.

The teaching on the surgical side was good and after the member of the staff had completed his round a conference was usually held in the X-ray room with the Radiologists, which was very instructive.

The nurses at Yale were all college graduates and were very kind but I did not thing that their standard of nursing was as high as that at Guy's The Head Nurse was addressed as Miss So-and-so and the term " Sister " in the States had a very different effect from that at home.

The Association of Internes and Medical Students arranged visits to many places of interest, amongst which were Fairfield State Mental Hospital, Laurel Heights (a modern sanatorium), a Child Guidance Centre, and a Hospital for Children with rheumatic heart disease.

During our stay in New Haven our social life was not neglected and we were entertained not only by A.I.M.S. members but by many members of the Hospital, and we spent all our week-ends away—three of them in New York. One week-end I spent with the Assistant Prof. of Vasc. Surg., Dr. Glenn, on a huge wooded estate in New Hampshire, and whilst there saw my first real Barn Dance.

One long week-end was spent in Boston where we were duly impressed with the massive Massachusetts General Hospital and its " ether dome " where on that memorable occasion over 100 years' ago ether was first demonstrated as an anæsthetic. While at Boston we were delighted to meet a Guy's man, Dr. David Stafford-Clark, who was working in the Psychology Department there. We also saw Cambridge and were very impressed with what we saw of Harvard.

At this point Bass and I parted company, Bass going to Chicago while I trekked South to Philadelphia.

Here I worked at the University Hospital and once again experienced the same wonderful American hospitality. An indication of this is the fact that we were entertained nearly every evening during our stay. In Philadelphia as at New Haven, the Staff of the Hospital and A.I.M.S. did all they could to make my stay a happy and instructive one and they certainly succeeded.

There was a great selection of very interesting cases and although I was attached to Dr. Kirby's team I " scrubbed in " with other teams on interesting cases. One example of these was an operation for portal hypertension on a girl of 20 who had already had a splenectomy.

I wandered on to the medical wards in my spare time and saw a dramatic recovery (by A. C. T. H. (adrenocortico-tropic-hormone)) in three days, of a young women crippled with rheumatoid arthritis.

From Philadelphia I travelled to Washington—a beautiful city—and saw all the sights that a tourist usually sees there as well as visiting the Walter Reed Military Hospital.

One the way back to Philadelphia I called at the Johns Hopkins in Baltimore for two days and met Dr. Reinhoff who welcomed me as if I were the prodigal son returned. Everyone spoke very highly of the members of Guy's Staff that had visited there and with best wishes to all at Guy's ringing in my ears I returned to Philadelphia. From there I visited the Amish Country and toured the Armstrong Linoleum Plant where 80 per cent. of the world's linoleum is made. I was very impressed with the first-aid station there where there was a minor operations theatre, a well-equipped X-ray room, and eye-testing apparatus.

My last fortnight I spent with friends in Detroit where I was entertained on a lavish scale—even by American standards. I spent two days in the company of a general practitioner in Canada whose work seemed much the same as that of his corresponding number in Britain. Later I saw the Niagra Falls and wended my way to Toronto, where at the Canadian National Exhibition I saw many cases of interest to an endocrinologist in one of the side shows !

Leaving Detroit on September 11th I flew to New York and sailed on the *Queen Mary* on September 14th.

While in the States we were impressed with the high regard in which Guy's is held abroad. We were always asked many questions about our N.H.S. as the American Press has so distorted the facts that no one knows what to believe. There is, as yet, no comparable scheme in the States but there is a voluntary hospitalisation insurance scheme known as Blue Cross.

Wherever we went we were received with typical American hospitality, which has to be experienced to be believed and perhaps the best measure of this is the fact that I gained 22 pounds in weight ! May I thank the Deans of Yale, and Guy's, the Students' Union of Guy's, and the Association of I. and M.S. of America for making this exchange possible and I hope that it will continue and enlarge in future years.

The Principles of Chiropody. By JOHN H. HANBY and H. E. WALKER. Bailliere, Tindall & Cox. *Price* 21*s*.

The authors of this handbook have had an unrivalled experience in the practice and teaching of chiropody, and have played a large part in the development of the art to its present high standing. The book is the outcome of a lifetime of experience and gives a clear and detailed account of the practice of chiropody, and elaborates the physiological and pathological bases on which it is founded. It will be of the greatest value to anyone interested in the subject.

P.G.E.

Correspondence

Milk

SIR,—The article on Milk by Roy Goulding in the *Gazette* of October 8th, 1949, is a very useful and informative summary of the situation, but the reader must not, even in the face of present legislation, consider that an optimal standard of perfection has been achieved.

Owing to the milk shortage, GOATS MILK is becoming increasingly popular. Persons are now rearing goats in large numbers, and retailing the milk for either drinking purposes or for manufacture into cheese. The conditions under which the milk is produced are often dirty, with a resulting low quality of milk.

The Milk and Dairies Acts and Orders app,y to COWS' MILK only, and there is no specific mention of goats' milk in the present law. Hence local authorities have difficulty in enforcing any hygienic standards in goat-sheds and goat dairies. Neither can tests for keeping quality of goats' milk be legally applied, and it is only when pathogenic organisms such as Fæcal Coliform Organisms are detected in a sample of goats' milk on sale for human drinking purposes, that further sale of the milk can be controlled.

Although it may not be a propitious moment to urge the necessity for more controls, I feel that there should be some strengthening of the existing law to cover the production, handling, and sale of goats' milk for human consumption, particularly where this is carried on on a large scale.

Yours, etc.,

JOHN WILDMAN.
Medical Officer of Health,
East Herts : Combined Districts.

16, Churchfields,
Broxbourne, Herts.

Guy's Diary

October — **ACADEMIC**

Exhibition. Medical and Dermatology Departments. "Addison's Contribution to Medicine." Gordon Museum.
Exhibition. Surgical Department. "Hæmataria."
24th. 1.00. Dr. Forman. Clinical Lecture. "A Patient Showing a Dermatitis Due to Gold."
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
25th. 1.00. Mr. P. V. Reading. Clinical Lecture. "Deglutition and its Anomalies."
12.00. Mr. A. Bulleid. "The Problem of the Pulpless Tooth." Dental Theatre.
27th. 4.30. X-ray Demonstration. Gordon Museum.
28th. 1.00. Dr. Douthwaite. Clinical Lecture.
2.15. Medical Department. Combined Round. Preclinical Classroom.
29th. 10.00. Surgical Department. Clinico-Pathological Meeting. Anatomy Theatre.
31st. 1.00. Mr. Doherty. Clinical Lecture.
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Department of Child Health. Film Show, "Polio-Diagnosis and Management." Anatomy Theatre.

November
Exhibition. Surgical Department. "Obstructive Jaundice."
1st. 12.00. Medical Department. Neurological Demonstration. Preclinical Classroom.
3rd. 1.00. Mr. Glover. Clinical Lecture.
4.30. X-ray Demonstration. Gordon Museum.
4th. 2.15. Medical Department. Clinico-Pathological Meeting. Pathology Lecture Theatre. "Ocular Tuberculosis."
7th. 1.00. Mr. Morgan. Clinical Lecture.
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

October — **OTHER ENGAGEMENTS**

24th. Rugby XV. *v.* Paignton. (Paignton).
27th. 5.00. Dental Society. R. O. Holland, Esq., M.R.C.S., L.R.C.P., L.D.S. Presidential Address. "Some Oral Manifestations of General Systemic Disease."
29th. Rugby XV. *v.* Old Alleynians. (Dulwich).
Hockey 1st XI. *v.* Orpington. (H.O.P.).
Hockey 2nd. XI. *v.* Orpington. (Away).

November
Hockey 3rd XI. *v.* Clescoe. (Away).
5th. Rugby XV. *v.* Old Blues. (H.O.P.).
Hockey 1st XI. *v.* Inland Revenue. (Away).
Hockey 2nd XI. *v.* Inland Revenue. (H.O.P.).

Sport

RUGBY

Guy's *v.* Aberavon

Lost—20 pts. to 13 pts.

This match was the hardest the Hospital has had this season, and the probability is that there will be few harder. The game was lost by 1 goal, 1 try, and 4 penalty goals to 2 goals and a try, and this score would suggest that there was no great disparity between the sides. On the day Guy's were fortunate not to be beaten more severely. The defence was weak and the Aberavon side was allowed too much freedom of movement.

The set scrums were poor, Guy's healing the ball infrequently and then so slowly as to cancel any hope of three-quarter movements.

Aberavon scored first and their try was converted. A fairly even battle was waged for some time after this and then Guy's took the lead by scoring twice in succession. The first try was scored by W. G. Davies following a very good break on the blind side by A. Large, the scrum half. The next try was scored by E. Williams following a good movement. Both were converted by D. le Clus.

The lead was short-lived as Aberavon scored again and their full-back proceeded to kick four penalty goals to win the match, interrupted only when Guy's scored another try through P. Rademan.

Guy's were not disgraced by losing but the game showed up several points which need attention. The scrummaging was bad. The side as a whole, but particularly the forwards, are much too hazy as to the rules. The three-quarter line lacks pace in attack and determination in defence.

Team—D. le Clus, B. M. Gray, T. Smith, E. S. P. Williams, E. W. S. Birch, J. P. le Clus, A. Large, C. T. M. Wilson, J. Robinson, J. Kirkbride, S. R. Knipe, N. Malyon, A. C. de B. Eksteen, W. G. Davies, P. Rademan.

Guy's *v.* Bedford

Lost—12 pts. to 3 pts.

Two changes were made in the side which lost to Aberavon last week. G. A. E. Baker came into the centre and C. Pook into the second row. The result of the game was both gratifying and disappointing. Bedford won by 3 penalty goals and 1 drop goal to one penalty goal. What was pleasing was that the Guy's pack outplayed a very heavy and experienced set of Bedford forwards and had more than their share from the scrums and line-outs. The defence throughout the side showed distinct improvement.

Bedford played with the wind in the first half and pressed continually. Guy's relieved things by very effective forward rushes. Most of the first half was spent in the Guy's part of the field and when the time came to change over, Bedford were leading by 6 pts. to nil. It seemed that Guy's might well pull this game off and certainly they tried well.

A penalty goal kicked by D. le Clus narrowed the margin and their several attempts at scoring went awry, in particular a good cross-kick by B. M. Gray. The pressure was maintained but faulty handling in the centre let down several hopeful movements.

In the last few moments Bedford scored another penalty goal and then they landed a drop goal.

It was a good game with sustained interest and very well refereed by Mr. Davey, a visitor from Monmouth. The unfortunate thing was that Guy's should have 9 pts. scored against them in penalty kicks. Unless there is some improvement a great many games will be lost from this cause.

ASSOCIATION FOOTBALL

SOUTHERN AMATEUR LEAGUE

Guy's *v.* West Wickham

At H.O.P. Won 4—1.

Saturday, 8th October, 1949.

The opening stages of the game found the Guy's defence hard pressed by vigorous West Wickham attacks. A defensive lapse by Lipington enabled their outside-left to fasten onto a ball and make a good shot, giving Fearn no chance. A tendency to be slow during these opening minutes gave West Wickham other opportunities which they failed to sieze. The Hospital defence gradually settled down, and by means of robust tackling and good positional play wore down the opposing attack.

Meanwhile, the Guy's attack moved into top-gear, Prince being prominent by his intelligent distribution of the ball. Their efforts were soon rewarded when a hard shot from Sturdy hit the underside of the bar, rebounded, and was signalled as having crossed the line. Cornhill working the ball cleverly sent a hard low shot towards the Wickham goal, the ball being deflected into the net by one of the defence.

Thus the second half saw Guy's leading by the odd goal of three. Guy's consolidated this advantage when Sturdy headed the ball in from a Leckie centre after a fine movement. Harris, our hard-

working centre-forward, sealed the fate of our opponents by bringing the ball under control and cleverly placing his shot out of the goalkeeper's reach.

The efforts of the Guy's attack must not be allowed to overshadow those of the defence, which was generally sound, amongst whom Howell's was outstanding at centre-half. A well deserved victory for Guy's, whose tackling was at one stage of the game just a little too keen.

Team : A. Fearn, D. Lipington, P. Holloway, D. Matthews, W. Howells, A. Swift, B. Cornhill, C. Leckie, D. Harris, A. Prince, E. Sturdy.

Guy's *v.* Ibis

Result : Ibis 1—Guy's 8.

The Hospital side maintained their unbeaten record on Saturday by defeating Ibis 8—1. This win gives the Hospital side five points out of a possible six from their first three league matches, and helps in the club's avowed policy to make its name well-known throughout Southern amateur football circles, after which we hope to raise our status in the hospital itself, a much tougher proposition.

Guy's won the toss and started with the wind at their backs. A supremacy was quickly gained and but for some indifferent shots a goal would have soon resulted. However, it was not till after 25 minutes that the hospital opened their account with an opportunist goal by Harris who followed up a shot that the goalkeeper could only parry and bustled the ball in the net. The second goal came from a beautiful shot by Leckie from the edge of the penalty area which left the home custodian helpless. Sturdy completed the scoring in the first half with a typical header from a cross by Leckie. The second half started as the first finished with Guy's attacking incessantly, and further goals were scored by Sturdy (two), Leckie, Harris and Cornhill. Harris's goal is worthy of special mention because a bullet-like clearance by Lipington was chased by the centre-forward who made no mistake with his finishing shot.

Ibis claimed their only goal five minutes from time, due to a defensive slip that gave their inside left a chance to take deliberate aim. Sturdy's "hat-trick" brought his tally for league matches to six.

The Hospital side was as follows :— A. Fearn, D. Lipington, P. Holloway, D. Matthews, D. Allen, A. Swift, B. Cornhill, C. Leckie, D. Harris, A. Prince, E. Sturdy.

HOCKEY

Guy's *v.* Wallington

At H.O.P. Lost 2—3.
8th October, 1949.

This, the first game of the season, was played on a fast and bumpy pitch. The play during the first half was fast and Guy's, though failing to make the most of their opportunities, had most of the game. The only goal of the first half was scored by Blake. Wallington rallied after the interval to make the game more even. Ten minutes before the end, when the score was 2—2, Guy's seemed to slacken. Wallington dominated the closing stages of the game and scored the deciding goal. Guy's should learn from this defeat that swinging the ball, quick hitting and playing hard till the final whistle are golden roles of hockey.

Team : F. H. Walker, D. Sonnenfeld, G. H. Danford, H. Carter, E. A. Murray (Capt.), C. Robinson, R. Hodson, C. H. Opie, D. E. Blake, H. Meyer, D. V. Duckworth.

Other results—

Guy's II *v.* Wallington II. Lost 1—3.

Guy's III *v.* National Physical Laboratories. Lost 2—6.

Hospital Information, etc.

NOTICES

SURGICAL STAFF CONFERENCES

Instead of on the first Monday in every month at mid-day, Surgical Staff Conferences will, in future, be held on a Tuesday, at 1.30 p.m., in the Clinical Theatre. These conferences will be called whenever a member of the Staff wishes to discuss a case of great clinical or therapeutic interest with his colleagues, and will be limited to one case.

Notices of these conferences will be circulated to members of the Staff and will be put on the Surgical Departmental Notice Board.

Y.H.S. SOCIETY

The Guy's Youth Hostles' Society will be planning its next week-end trip to the Home Counties, in the Histology Library on Thursday, October 27th next, at 5.0 p.m. We cordially invite those interested, whether medical, dental, physiotherapist or radiographers, to join us.

United Hospital Regatta will be held on Wednesday, November 16th, 1949, at Putney (Thames Rowing Club).

DEPARTMENT OF VENEREAL DISEASES

New time of Sessions for New Patients. October, 1949.

	Men.	*Women and Children.*
Mon.	9.30 a.m. to 1.0 p.m. and 4.30 p.m. to 7.0 p.m.	11.0 a.m. to 3.0 p.m.
Tues.	9.30 a.m. to 1.0 p.m.	2.0 p.m. to 6.0 p.m.
Wed.	4.30 p.m. to 7.0 p.m.	11.0 a.m. to 3.0 p.m.
Thur.	9.30 a.m. to 1.0 p.m.	2.0 p.m. to 6.0 p.m.
Fri.	4.30 p.m. to 7.0 p.m.	3.0 p.m. to 6.0 p.m.
Sat.	9.30 a.m. to 2.0 p.m.	9.30 a.m. to 1.30 p.m.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

G. F. Gibberd has been elected representative of the Fellows to the Council.

PASS LIST

UNIVERSITY OF LONDON

GENERAL SECOND EXAMINATION FOR MEDICAL DEGREES.

September, 1949.

W. F. Davies
A. I. Fram
B. K. Higgins
J. G. Lymbery
H. St. J. Mansbridge
J. R. Wiernik
E. S. P. Williams

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

M.R.C.O.G.

July, 1949.

V. Y. Bockner
G. M. Evans
G. W. Garland
G. T. Hammond

UNIVERSITY OF OXFORD

B.M., B.Ch.

Long Vacation, 1949.

Forensic Medicine and Public Health.

J. M. D. Hooper
W. D. May
D. J. Muller
W. G. Rhys-Jones
J. Taylor
C. N. Watson
J. H. Wilson

Special and Clinical Pathology.

J. M. D. Hooper
D. J. Muller
W. A. Openshaw
W. G. Rhys-Jones
J. Taylor
C. N. Watson
J. H. Wilson

UNIVERSITY OF CAMBRIDGE

Pharmacology.

Michælmas Term, 1949.

W. V. Agnew
A. P. Blower
A. Fairley
H. W. S. Francis
B. G. S. F. Vergano

GUY'S HOSPITAL REPORTS

1948, Vol. 97.

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CHANGES OF ADDRESS

G. F. Barnes, M.B., B.S., Golden Acres, Cowbeech, nr. Hailsham, Sussex. (Tel. Hurstmonceux 3279.)

W. H. Smith, M.B., B.S., Dept. of Diagnostic Radiology, Bristol Royal Infirmary, Bristol 2.

M. G. Trott, L.D.S., R.C.S., Droxford House, Charles Road, St. Leonards-on-Sea, Sussex. (Tel. Hastings 613.)

D. J. Wigginton, M.B.E., M.R.C.S., L.D.S., Grantley, 43, Court Road, Eltham, S.E.9. (Tel. Eltham 1706.)

MARRIAGES

FOOKS—CROWELL.—On September 3rd, 1949, at St. Saviours Church, Westcliff-on-Sea, Allan Arthur William Fooks, L.D.S., R.C.S. (Eng.), D.D.S. (U.S.A.), of Sonning Lodge, Eastwood lane, Westcliff-on-Sea, Essex, to Emily Jane Crowell, Charlotte, N. Carolina, U.S.A.

HONE—LIDDLE.—On 3rd September, 1949, at All Saint's, Limuru, Kenya, Desmond Ralph Hone, L.D.S., R.C.S. (Eng.), to Mary Patricia Liddle.

JORDAN—MACENTEE.—On October 3rd, 1949, Nurnberg, Germany, Howard B. Jordan, Colonel U.S.A. Army, to Nora MacEntee (A.P.O., 696A, U.S. Army).

SELLEY—SMITH.—On Saturday, September 24th, 1949, at Holy Trinity Church, Sydenham, London, Wilfred Selley, Lt. R.A.D.C., to Audrey Smith, of Forest Hill, London.

EDS. {R.G. P.A.Z.

The Smoker's Match

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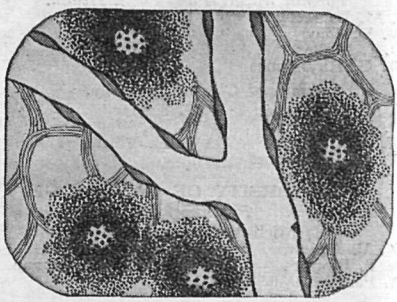

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Literature and further information sent on request to the Medical Department

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GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LXIII *No.* 1599 *5th November 1949* *Ninepence*

PASSIM

AS far as the clinician is concerned almost any report on a special investigation represents something of a "snare and delusion." The heading is ostentatious, the characters clear and typewritten, the terms impressive and the authority, apparently, unimpeachable. Yet behind that neat façade of reliability and precision lies a whole suite of variations and uncertainties. Sampling, in the first place, may be far from representative, techniques abound with experimental errors—small often, but inescapable, interpretation, if the pathologists, hæmatologists, bacteriologists and the like will allow us to say so, is at the mercy of human fallability and the tests themselves can seldom be specific. Trouble arises in practice because the clinician is all too mindful of the vagueness of the history and the difficulty at times of eliciting definite physical signs and, by contrast, the special report may masquerade as a recognisable and staunch figure amidst an array of diagnostic uncertainties.

Even more is the student likely to suffer from such misapprehension. To him, as a tyro, clinical acumen can come only with experience. Meanwhile he gains false confidence from the results of special investigations, the repertoire of which extends as each day passes and the fashion for which is attributed to our transatlantic colleagues. How can this danger be avoided? Two causes immediately suggest themselves: first, that the student should be offered not only a series of clinical appointments during his training but also a stay, brief and revealing, in each of the more prominent of the special departments. There he will see and perhaps undertake the conduct of routine tests and appreciate their true importance by so doing. Better this than the perfunctory attendance at a few formal lectures and staged demonstrations from which he will gain little and remember less. Secondly, he must do the tests for himself. On some firms this is an accepted and admirable procedure. But are people aware of the conditions under which ward-clerks must work? These poor, benighted creatures, the lowest form of animal life in the hospital kingdom find, if conscientious, that their time is more than fully occupied. Between lectures, rounds, demonstrations, history-taking, out-patients and examinations they must do the housemen's bidding by taking blood, examining specimens, performing test-meals and so on. Not for them is the service in the wards which the elect enjoy. Circumstances, of course, vary, but an extraordinary amount of time is often wasted in searching for the apparatus required and, just occasionally, that most desirable co-operation from those in charge may seem to be lacking. As for the laboratory facilities, a controversial subject is at once raised. The department at the top of Hunt's House is extremely useful and the staff there do their best to see that microscopes and other items are always available in proper condition. The provision of blood-taking outfits in the wards, arranged by the Department of Medicine, has also been a most valuable innovation (Surely some method can be afforded so that the pipettes can be cleaned easily and effectively). What, regrettably, is all too obvious is the absence of that attitude which may well be described as *esprit-de-corps*. Until every student realises that with communally-used apparatus someone else will always follow and suffer in the wake of neglect and irresponsibility so will the existing state of affairs with dirty microscopes, cracked slides, unclean pipettes, empty bottles and so on inevitably prevail.

WE announce, with deep regret, the death in Nuffield House on 2nd November, 1949, at the age of 75 years, of Sir Herbert Eason, C.B., C.M.G., M.D., M.S., F.R.C.S., President of the General Medical Council, sometime Dean of the Medical School and Superintendent of the Hospital. A memorial service is to be held in the Chapel on Friday, 11th November, at 1.45 p.m.

A limited number of Christmas Cards are on sale in The Gazette Office, **6, St. Thomas Street, S.E.1.** Prices 10*s.* 0*d.*, 5*s.* 0*d.* and 3*s.* 0*d.* per dozen, including envelopes (per post 6*d.* extra). To avoid disappointment early purchase is advised.

Streptomycin—Some Notes on its Use

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UNTIL the end of October, streptomycin was provided by the Ministry of Health for the treatment of certain specified conditions in which it was known to be of proven value. As supplies of the drug became more plentiful, the number of these was increased from time to time and in latter months had embraced a moderately wide field. From 1st November, 1949, however, all restrictions on its use have been removed and it may now be supplied on prescription as each doctor wishes.

While streptomycin is a valuable addition to our therapeutic armoury, its indiscriminate use may have unfortunate results. It would, therefore, seem appropriate at this time to summarise briefly the main principles upon which its successful administration depends.

PRINCIPLES OF STREPTOMYCIN THERAPY.

FIELD OF ACTION OF STREPTOMYCIN. The majority of micro-organisms are sensitive to streptomycin in vitro, but in view of its toxicity and the speed with which it produces resistant strains, its use should be reserved for those infections in which the organism responsible is insensitive to penicillin and the sulphonamides.

The most important example is, of course, the tubercle bacillus, but streptomycin is also of great value against many gram negative organisms including *Hæmophilus influenzæ*, *Bacillus proteus*, *Pseudomonas pyocyaneus*, *Friedlander's bacillus*, and certain sulphonamide resistant strains of *Bacillus coli;* of the gram positive cocci, *Streptococcus fæcalis* and *Staphylococcus pyogenes* also fall into this group.

There are several conditions, including the typhoid group of diseases and to a lesser extent abortus fever, which clinically do not respond well to streptomycin although the organism responsible is sensitive in vitro.

Recently the treatment of whooping cough with streptomycin has proved most encouraging and excellent results have been obtained in the treatment of two venereal infections due to gram negative bacilli, namely granuloma inguinale and chancroid.

Although unimportant in this country, mention must be made of the brilliant results obtained in America in the treatment of tularæmia and there seems reason to believe that streptomycin will also be effective against plague.

Streptomycin appears also to be of value in the treatment of actinomycosis, if penicillin is unsuccessful; here dosage should be more prolonged than that needed to control the majority of non-tuberculous conditions.

RESISTANCE.

The greatest defect of streptomycin is the readiness with which bacteria develop resistance to it. This sharply limits its usefulness in treatment. The majority of bacteria are capable of developing resistance in a few days. With the slow growing tubercle bacillus the process takes several weeks or months. Once resistance has occurred in an infecting micro-organism further treatment with streptomycin is ineffective. Almost all the evidence suggests that resistance once acquired becomes a permanent characteristic. A resistant strain remains resistant in spite of passage through a series of animals. This raises the possibility, fortunately not yet reported in man, that streptomycin resistant strains of the tubercle bacillus may become disseminated among the population causing a type of tuberculosis in which the drug is ineffective. An awareness of the danger should help the doctor to resist the very great pressure that may be brought upon him to give streptomycin to an unsuitable case. In human tuberculosis drug resistance appears in 10 per cent. of patients in the first four weeks. It increases sharply between six and eight weeks after the beginning of treatment, so that at two months 50 per cent. of patients are resistant to the drug. After four months the figure rises to 80 per cent. About 20 per cent. of patients apparently never become resistant. This means that while the majority of patients can only expect to benefit from a single course of treatment, there remains a minority in whom subsequent courses of streptomycin may be effective.

TOXICITY.

The most important toxic effect of streptomycin is upon the vestibular apparatus. The onset of these symptoms is related to the size of the daily dose, the duration of treatment and the state of the renal function. They are seldom severe in patients receiving 1 gramme daily for 60 days or less, provided that renal function is normal. In patients receiving 2 grammes a day vestibular damage may be expected at any time after the fourth week. It is due to the drug itself, and not, as was at first thought, to impurities. Once vestibular damage has occurred the symptoms persist for several days or weeks, whether treatment is continued or not. The symptoms gradually disappear although the damage can be shown by caloric testing to be permanent. Recovery is due to a transfer of vestibular function to other special senses. This process is more likely to be complete in younger patients. In older patients some ataxia may remain and may be disabling, especially in the dark.

Streptomycin also causes deafness, but only after prolonged administration of doses larger than 2 grammes which are very seldom used. Deafness following tuberculous meningitis is more often due to the disease than to the drug.

Minor toxic reactions are quite common. They include pain at the site of injection which is only partially relieved by procaine, drug fever, eosinophilia, circumoral paræsthesiæ, minor skin eruptions and nausea or vomiting. Many of these reactions are allergic in nature and can be relieved by the antihistamine drugs. To prevent nausea and vomiting it may be necessary to give antihistamines for as long as streptomycin is continued. Skin eruptions, if slight, are of no significance, but if they become severe the drug should be withdrawn, as exfoliative dermatitis sometimes occurs.

Renal irritation is shown by the appearance of albumen and casts in the urine. If renal function is normal at the beginning of treatment, renal irritation can be ignored. Impaired renal function may cause excessively high blood levels of streptomycin and lead to unexpected neurotoxic effects with moderate doses.

DIHYDROSTREPTOMYCIN.

Attempts have been made to modify the toxic effects of streptomycin without impairing its antibacterial activity. Dihydrostreptomycin, which is prepared when streptomycin is reduced in the presence of platinum, represents almost the only attempt that has succeeded. Its antibacterial power is as great as that of streptomycin and it has the advantage that it produces vestibular damage more slowly. Its neurotoxicity is little more than half that of streptomycin.

Resistance to dihydrostreptomycin is as great a problem as it is with streptomycin. Organisms become resistant equally quickly to both preparations and if resistant to the one are always resistant to the other.

The other minor toxic effects mentioned above may occur equally with either drug, but dihydrostreptomycin has the valuable property of being well tolerated by patients who have become hypersensitive to streptomycin.

The principal disadvantage is that it is probably too irritant to be safely given into the spinal theca.

The dosage is the same as that for streptomycin.

THE USE OF STREPTOMYCIN IN TUBERCULOSIS.

In general, streptomycin is most effective in tuberculosis when the inflammatory and exudative element in the disease is maximal, and when caseation, tissue destruction, excavation and fibrosis are minimal. It is thus most effective in tuberculosis of any organ when the process is of recent onset and acute.

It is also particularly effective in securing healing of tuberculous infiltration and ulceration of mucous surfaces. Tuberculous ulceration whether of the larynx, the bronchi, the bladder or the intestine responds in a way that is little short of miraculous.

MILIARY AND MENINGEAL TUBERCULOSIS.

Streptomycin is indicated in every case of miliary tuberculosis and tuberculous meningitis, because without it almost all patients die rapidly.

Miliary tuberculosis responds dramatically to streptomycin and often the radiological appearances became normal in two to three months. The outlook, however, is always uncertain because meningitis may develop in the course of the disease, even when the patient is having streptomycin. A combined miliary and meningeal infection carries a much graver prognosis than does either by itself. Another outcome that may occur under streptomycin is the evolution of miliary disease into the adult type of pulmonary tuberculosis.

The recommended dosage is 20 mg. per lb. body weight up to a maximum of 2 grammes daily by intramuscular injection. There is nothing to be gained by giving this in more than two daily injections. If there is meningitis, it is imperative to give the drug intrathecally as well, in doses of 25–100 mg. daily dissolved in 5–10 c.c. of saline or cerebrospinal fluid. This must be kept up for many weeks. In the only series in which more than 50 per cent. of cases recovered, intrathecal treatment was given daily for at least two months and intramuscular treatment for six to nine months. There is a great danger of relapse if treatment is stopped too early.

Tuberculous meningitis is complicated by two interrelated mechanical problems due to the formation of fibrinous exudate at the base of the brain. This exudate provides a situation where tubercle bacilli may multiply beyond the reach of streptomycin and it interferes with the circulation of the cerebrospinal fluid leading to spinal block and hydrocephalus. It has been suggested that streptokinase, by its fibrinolytic action, may dissolve this exudate as it forms, and keep the tubercle bacilli exposed to streptomycin. After a block has occurred it has been shown that the effective administration of the drug may sometimes be continued if burr holes are made in the skull, when the streptomycin may be injected into the lateral ventricles or the interpeduncular space.

It is an unexplained fact that resistance is seldom a problem in tuberculous meningitis.

PULMONARY TUBERCULOSIS.

Streptomycin is not indicated in every case of pulmonary tuberculosis, because in many patients there is too much caseation, excavation and fibrosis for the drug to be effective. All that happens in such patients is at best a temporary improvement, soon followed by relapse. Such patients may become a public danger as open carriers of resistant organisms.

The general indication has been defined as " pulmonary tuberculosis in which the lesion is of recent development, is progressive and is unlikely to benefit from conventional methods (*e.g.* bed rest and/or collapse therapy) alone."

The types of disease that fall into this category are :—

(i) Rapidly advancing pulmonary tuberculosis, including tuberculous pneumonia, especially if of recent onset. Collapse therapy is dangerous or impracticable in such cases at first, but it may sometimes be safely undertaken after a few weeks of streptomycin.

(ii) Acute spreads of disease such as may follow hæmoptysis, collapse therapy or thoracoplasty. Such spreads are only an occasional complication of thoracoplasty, and streptomycin is not recommended as a routine cover for every operation. This would have the undesirable effect of inducing streptomycin resistance in many patients unnecessarily.

(iii) It is, however, indicated to cover resections of tuberculous lung, for here there are great risks of disseminating the disease within the lungs or pleura.

(iv) In pulmonary disease complicated by ulceration of mucous membranes. Tuberculous laryngitis, tracheobronchitis and enteritis respond very well to streptomycin. Tuberculous tracheobronchitis may be suspected when a patient has a persistently positive sputum in spite of apparantly adequate control of his lung lesion ; where there is stridor or localised rhonchi ; and where atelectasis occurs spontaneously or following collapse therapy. The diagnosis can be confirmed by bronchoscopy.

Tuberculous sinuses can often be induced to heal by a course of streptomycin. Sometimes additional help can be obtained by the local instillation of 0.1 to 0.5 grammes of the drug dissolved in a convenient quantity of saline into the sinus. This method is particularly valuable in dealing with Semb space infections after thoracoplasty

Dosage. A dose of 1 gramme daily given in one or two intramuscular injections is adequate for all but the most severe pulmonary infections. There is little danger of serious toxic effects if this dosage is maintained for two months. It is known that after two months treatment about half the patients will have become resistant. There is some evidence to show that 0.5 grammes may be an adequate daily dose and that with this dosage toxic effects do not occur. But it is too early to rely as yet upon this smaller dose.

Contra-indications. The principal contra-indication is chronic disease marked by gross structural changes in the lungs, unless the disease has just advanced by a recent spread. Streptomycin is ineffective in the presence of caseous matter and tuberculous pus. It is, therefore, largely useless in the treatment of tuberculous empyema. The most it will do is to cause some reduction in toxæmia.

As has been said above, the factor that limits the value of streptomycin is the development of resistant organisms. It is not possible to rely on having more than one period of six to eight weeks in the whole length of the patient's illness, when there can be reasonable certainty that streptomycin will be effective. It is, therefore, imperative that the drug should not be used when conventional methods of themselves are likely to succeed, or indiscriminately in every case. It should only be used in suitable cases after a careful assessment of the patient, and as part of a therapeutic plan, in which collapse therapy, if needed, is instituted at the proper time to maintain the control of the disease initially established by streytomycin.

OTHER TUBERCULOUS CONDITIONS.

Urinary. Tuberculosis of the renal tract illustrates the general principle that ulcerated mucous membranes respond well to streptomycin whereas caseating and destructive lesions of parenchyma do badly. The only lesions of the kidney itself which do well are the earliest ones for which nephrectomy is judged to be too drastic. On the other hand, tuberculous ulceration of the bladder responds well to streptomycin. This is fortunate for the patient for it relieves him of much of the frequency and dysuria that is such a distressing feature of tuberculosis of the renal tract. The risk of disseminating resistant tubercle bacilli is less in urinary than in respiratory tuberculosis; and there is a valuable place for streptomycin in the palliative treatment of this disease. Its place in the radical treatment of urinary tuberculosis is less certainly established.

Glands and Bone. In tuberculosis of glands and bone, the place of streptomycin is more doubtful. Tuberculosis of these organs is always associated with caseation, destruction of tissue and mechanical factors which make the value of streptomycin uncertain. Streptomycin is no substitute for the established surgical methods of dealing with these problems. It may prove to be a useful adjuvant in securing readier healing and fewer complications after operation.

Abdominal. Streptomycin is indicated, as has been mentioned above, in all cases of tuberculous enteritis; for the symptomatic relief it affords may be dramatic.

In tuberculous peritonitis it is probably of value, though the results are much more difficult to interpret in the absence of any records of controlled observations on this subject.

Skin. In tuberculosis of the skin, apart from the problem of tuberculous sinuses which has been mentioned above, there is not yet enough evidence to assess its value.

Dosage. 1 gramme daily is probably a safe and effective dose for all tuberculous infections other than miliary and meningeal disease. Treatment should be continued for a minimum of 2 months.

THE TREATMENT OF NON-TUBERCULOUS CONDITIONS.

Most non-tuberculous conditions that are going to respond to streptomycin do so within the space of two or three days. If the response is not satisfactory the development of streptomycin resistant organisms is frequently extremely rapid, and they have been shown to be present as early as the fourth or fifth day of treatment. A prolonged course of treatment, therefore, is undesirable, but it is essential that an effective blood level of streptomycin should be maintained continuously during the first few days of treatment. It is unwise to attempt to do this with one or two large daily doses, and most authorities agree that in the majority of non-tuberculous conditions the daily dose should be divided and given at four hourly intervals by intramuscular injection. The shorter course and the smaller total dose make toxic reactions far less likely to occur than when the drug is used in the treatment of tuberculosis.

The more important organisms against which streptomycin should be used have already been mentioned. The dosage and method of administration must of necessity vary with the site of infection. Some of the commoner conditions in which the drug has proved of value will briefly be discussed.

URINARY INFECTIONS. A suggested dosage is 0.5 gramme intramuscularly 4 hourly for four days. Results are poor in the presence of urinary obstruction and if possible any mechanical problems should be dealt with before streptomycin is given. Patients with suprapubic drainage do notoriously badly as reinfection is almost inevitable. It is important to keep the urine alkaline during the administration of the drug as this greatly enhances the effect of streptomycin.

MENINGITIS.

By far the commonest organism which causes a meningitis unaffected by penicillin and sulphonamides but responsive to streptomycin is *Hæmophilus influenzæ*. This condition nearly always occurs in children.

A total daily intramuscular dose of 20 mg. per lb. body weight should be given in six 4-hourly doses, in addition to intrathecal injections of 25–100 mg. in 5 c.c. of saline or cerebrospinal fluid. Treatment by both routes should be continued until the cerebrospinal fluid has been sterile for at least seven days. Most authorities administer full doses of penicillin and sulphonamides in addition, as these drugs have been shown to exert some influence on the course of the disease.

Treatment of *Hæmophilus influenzæ* meningitis by this method is reputed to result in a recovery rate of 80 per cent. Streptomycin administered along the above lines is also indicated in the meningitis, often of mixed bacterial origin, that occasionally follows lumbar puncture or spinal anæsthetics.

INTESTINAL INFECTIONS.

Although the treatment of the typhoid group has proved so disappointing, good results have been obtained in several other intestinal infections which penicillin and the sulphonamides had failed to control. The shigella and certain members of the salmonella group are sensitive in vivo. In addition the normal non-pathogenic inhabitants of the bowel are very sensitive, and the intestinal tract can be sterilised with streptomycin. This may sometimes be of benefit before major surgical procedures involving the large bowel.

A total daily dose of 4 grammes administered half by the intramuscular and half by the oral route for one week has been recommended.

PULMONARY INFECTIONS.

Streptomycin has been given with success in the treatment of lung infections due to gram negative organisms. It is essential in these cases to give a large initial dose, as the rapid onset of resistance appears particularly likely to occur. A daily dose of 4–6 grammes in six 4-hourly injections is probably required for the first two or three days.

WOUND INFECTIONS.

There is a place for streptomycin in the treatment of wounds infected with organisms insensitive to penicillin and the sulphonamides. In practice the organism is usually found to be *Bacillus proteus* or *Pseudomonas pyocyaneus*. One scheme of treatment that works well is to give 4 grammes a day in 4-hourly divided doses for the first two days after which the dosage is halved. The duration of treatment will depend upon the appearance of toxic symptoms or of streptomycin resistance.

In cases of superficial infection streptomycin has also been administered locally by 3-hourly insufflation in a powder consisting of streptomycin 1 gramme, penicillin 150,000 units and sulphathiazole 9 grammes.

This treatment may be brilliantly successful but very often resistance emerges so early that the treatment fails.

SEPTICÆMIC CONDITIONS.

In the rare cases where a penicillin-resistant, streptomycin-sensitive organism is proved to be responsible for a septicæmia, 4-hourly injections of streptomycin should be given to a total daily dose of 4 grammes for the first two or three days, after which it may be reduced if the clinical condition warrants. If bacterial endocarditis is suspected treatment should be continued for two or four weeks.

Finally, the patient who is suffering from a pyrexia of unknown origin which has failed to respond to penicillin and the sulphonamides, must be considered. It may be felt that streptomycin should be tried empirically. Such a course would seem reasonable, but it is considered that in these circumstances full doses should be given for a period of not longer than five days. If there is no obvious response the drug should be stopped as it will do no good.

CONCLUSION.

Streptomycin now holds a place second only to penicillin among the antibiotic drugs. Like all other drugs, it has its limitations. In non-tuberculous infections its place may soon be taken by the newer antibiotics such as aureomycin and chloromycetin which are given by mouth and which do not so readily induce bacterial resistance.

In tuberculosis its place is as yet unchallenged. It remains the first drug to make the chemotherapy of tuberculosis a practical proposition, albeit in a limited way until the problem of bacterial resistance has been overcome. The future may lie in the development of better substitutes for streptomycin or in the discovery that streptomycin can be made more effective in combination with other substances such as promizole or para-amino-salicylic acid (P.A.S.). Much remains to be done.

Correction of Deformities of the Jaws

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Professor Emeritus of Oral Pathology and Brackett Professor of Oral Surgery, University of Harvard and Massachusetts General Hospital.

A Lecture delivered at Guy's Hospital Dental School on Monday, July 18th, 1949.

GENTLEMEN,—I have been asked to give you a lecture on some subject of my choice, and I thought it might be well to discuss with you the correction of some deformities of the jaws, both of the type so commonly seen to-day as the result of war or accident and those of congenital origin. I have brought with me a number of lantern-slides of cases which I shall show in order to demonstrate some of the techniques I have been using for the correction of these deformities. This, of course, does not mean that there are not other techniques or other methods which are just as good. I had the pleasure yesterday of seeing one of your own centres at East Grinstead, where I am sure a great deal of very fine oral surgery is being done.

Maxillary Protrusion.

My first example is of a rather simple case of maxillary protrusion which we see quite frequently. It illustrates a developmental defect which may be corrected by orthodontic means at the right time. When that right time has passed it is generally not possible to accomplish very much, and sometimes such patients develop an inferiority complex because of their facial expression. This was the case with the young lady whose portrait I show you. She wanted her maxillary protrusion—the pear-shaped arch—corrected. This can be done by the simple method of extraction of the anterior teeth and their replacement later. In this instance it required some courage to advise the sacrifice of rather beautiful teeth, but the patient was delighted with the result, and a few weeks afterwards she was engaged to be married.

From the picture of the dental condition in this instance it will be noticed that the incisors traumatised the palatal mucosa, so that it was not a cosmetic problem only, but a functional problem also. What was done was this. The anterior teeth were removed in the usual manner, after which the anterior labial cortical plate was removed, so that only the palatal cortical plate remained. This, of course, formed a ridge which was useful for denture bearing because the palatal plate is quite a solid piece of bone which can be easily retained. An alveoplasty was done and the incision closed. The dentist made her a denture, and the result was very pleasing, her appearance being considerably improved, as well as satisfactory from the functional point of view.

Deformities due to Malunion of Maxillary and Mandibular Fractures.

In most of our malformations we like to make our improvement, not by the extraction of the teeth, but by retaining the teeth and operating somewhere else in the bone.

Case of Malunited Maxillary Fracture.—It sometimes happens that after automobile accidents or war injuries a patient has a maxillary deformity, either retraction or protrusion. Osteotomy in a maxillary deformity is possible and gives good results if the teeth have occluded before the deformity occurred. The difficulty in the case just described was that the young girl's teeth could not be satisfactorily occluded because, the case being a congenital one, they had never occluded properly; whereas in a case of accident the probability is that the teeth had been previously in perfect occlusion.

The next patient had a marked protrusion due to malunion of a horizontal fracture of the upper jaw. She had an osteotomy of the maxilla with the result shown in my next picture. It was taken about three months after operation, and it can be seen where the incision has been made on both sides of the alveolar mucosa. After stripping the muco-periosteum from the bone, it was possible by means of an osteotome or chisel to cut through at the places where malunion had occurred. Working from the antero-posterior direction, it is generally possible by means of leverage to break the partitions so that the blood supply of the posterior superior alveolar artery will be intact. There is no interference with the blood supply or the nerve supply of the teeth.

Three Cases of Malunited Mandibular Fractures.—The next patient had been in an automobile accident and had a bilateral mandibular fracture. Treatment was unsatisfactory or incorrectly carried out, and she had only three teeth that occluded (Fig. 1). The X-rays showed immediately that there was overlapping of the fragments at the angle of the jaw (Fig. 3). The fracture had occurred posteriorly to the last molar, and the fixation was not properly carried out. Such fractures, even if they are several months or even one or two years old, are generally not very firmly united, even though the union may seem solid. The union occurs between the cortical bones, and does not

involve the cancellous bone. Generally it is a fibrous union, so it is possible by means of osteotome or chisel inserted at the site of the fracture to separate again the two pieces by means of leverage. In a bilateral fracture it will be necessary to separate the pieces on the other side in order to make proper replacement. It is not necessary to have a complete separation on the other side however; it need be just sufficient to manipulate the anterior and posterior fragments and bring the teeth into occlusion. Proper fixation is then carried out—first the fixation of the fragments and then intermaxillary wiring. The fixation of the fragments is carried out by means of a transosseus wire or a bone plate. The difference between a bone plate and wire should be understood. A wire has a tendency to draw the fragments together; a bone plate is more likely to keep them apart. In this case it was decided to have a bone plate to keep the two pieces apart, packing the space with bone chips so as to increase the length of the jaw (Fig. 4). Satisfactory occlusion was obtained (Fig. 2).

My next is a very similar case of an American soldier who had been treated in the American Army in Germany, but who had had concussion so that it was not possible there to treat his fracture very satisfactorily, and only temporary measures could be undertaken. Therefore again an open bite resulted. On X-ray examination it was found that malunion occurred and that an unerupted tooth had been left in the fracture line on the right. It was a question of removing the tooth and reopening the fracture. On the other side the fracture was in the neck of the condyle, and here I relied on the ability of the condyle to adjust itself rather than opening the fracture again.

The fracture on the right was separated, as I have shown in the previous picture, and then wired. Splints had been placed on the upper and lower arch before the operation, and it was only necessary to apply intermaxillary wires to lock the teeth together. (The post-operative appearance of the occlusion was shown on the screen).

Occasionally the condylar fractures give an unsatisfactory result when treated conservatively. I am one of those who believe that certain fractures in the neck of the condyle should be reduced by an open operation and wiring. Sometimes under conservative treatment for these fractures, especially fracture dislocations, the patient has no great discomfort. Other patients, however, have pain and are unable to masticate properly. In the following case an open reduction was done because of the very poor position of the condylar fragment (Fig. 5). You will observe the pins inserted after reduction of the fracture dislocation in order to prevent the condyle from losing its position during the recovery from anæsthesia (Fig. 6). During such recovery mandibular movements are likely to re-dislocate the condylar fragments by the pull of the external pterygoid muscle, and the pins shown in the picture serve for the prevention of such dislocation. They are needed only for two or three days, after which the patient does not have such strenuous muscular movements and therefore the fragment will stay in place. The picture I show you was taken about two or three weeks after operation just to see whether the fragment was still properly located, and you will see that it is (Fig. 7).

Mandibular Protrusion.

In the mandible we find frequently malformations which are developmental and beyond the orthodontist's skill. These are excessive mandibular protrusion, retrusion, and the so-called open bite. It is necessary in correcting these deformities to decide first what methods should be used. Some are enthusiastic about an osteotomy in the ascending ramus or an operation carried out at the neck of the condyle. These can be closed or open. There are others who prefer the operation in the horizontal ramus. I belong to the latter group and do most of my cases in that fashion. Occasionally, however, I do them in the neck of the condyle if the adjustment does not have to be very accurate. In operations in the horizontal ramus it is necessary to determine how large a size of bone should be taken out, and what shape this piece of bone should be. It is quite natural that if a parallelogram be cut the jaw can be set back, but this will not close an open bite, while by means of a V excision the bite would be closed on the anterior part, though only a slight correction of protrusion could be obtained. (Here Prof. Thoma showed a drawing which he employs to decide on the shape of the piece of bone to be taken out. He described how certain angles and distances are obtained, and thus accuracy is ensured in the procedure at operation).

The next case is that of a young man who had a protrusion which did not cause too great facial deformity, but was rather awkward from the point of view of mastication He had lost some of the first molars, which made this an ideal case for an operation to be performed in the horizontal ramus. There are three ways of doing this operation: (1) The operation may be performed intraorally. We used to be afraid of intraoral procedures before we had penicillin, but with penicillin the operation can be performed with practically no risk of infection. With this procedent we avoid external

CASE OF MALUNION OF BILATERAL FRACTURE OF MANDIBLE.

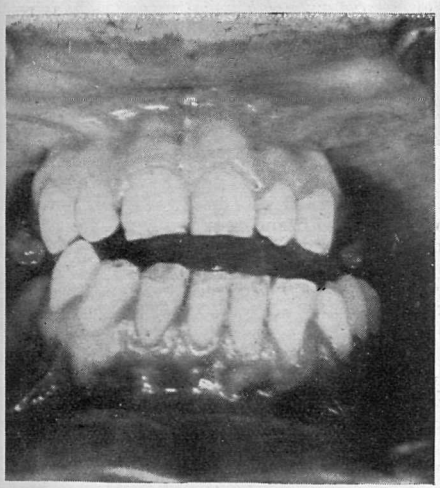

Fig. 1.—Malocclusion which has resulted.

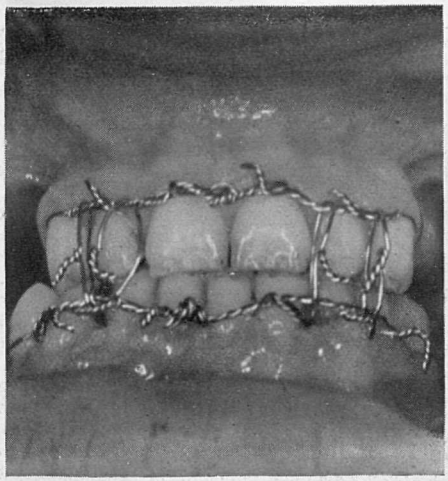

Fig. 2.—Occlusion after revision of fracture fixed by Risdon wiring.

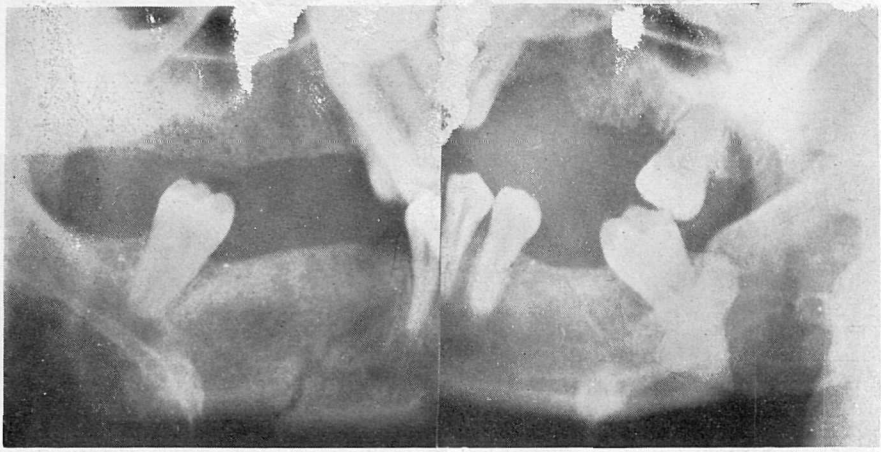

Fig. 3.—X-rays of Left and Right Side showing over-riding of fragments.

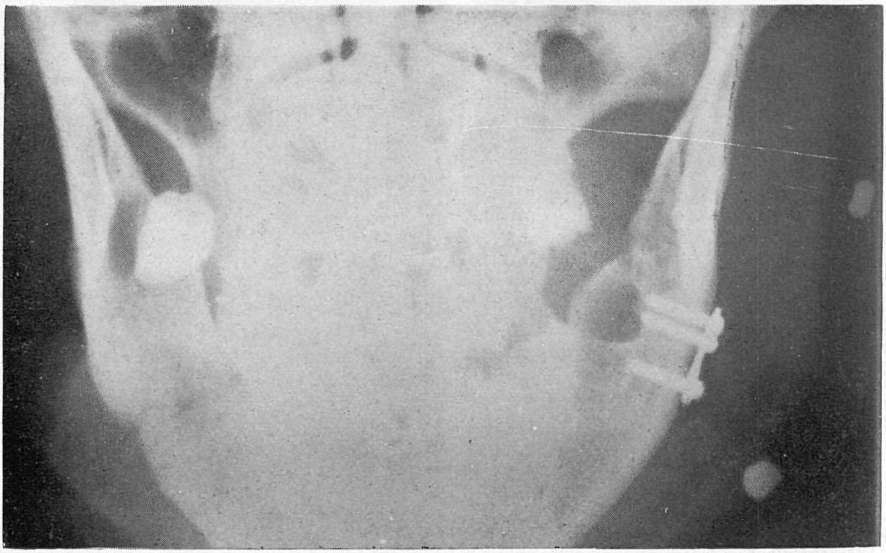

Fig. 4.—Post-operative X-ray showing result of revision and fixation by means of bone plate.

OF FRACTURE-DISLOCATION OF CONDYLE.

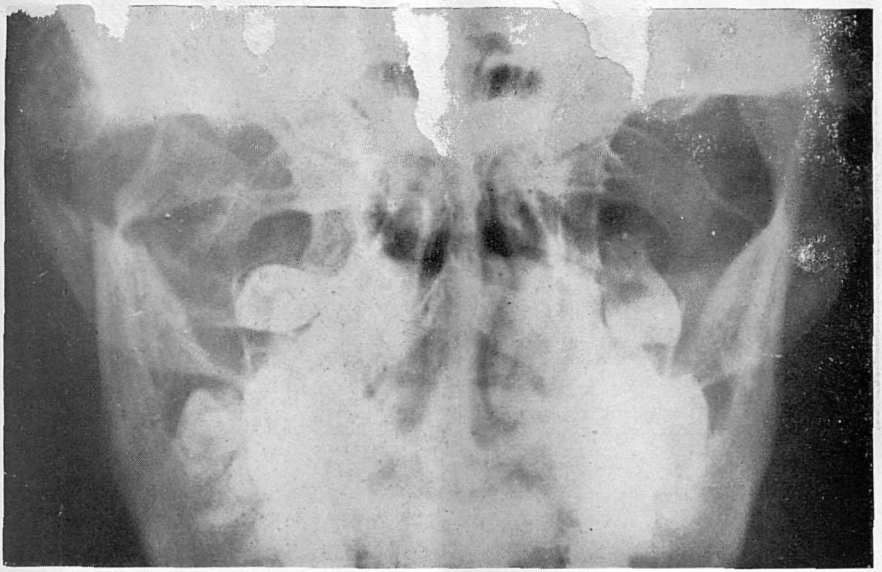

Fig. 5.—Pre-operative X-ray.

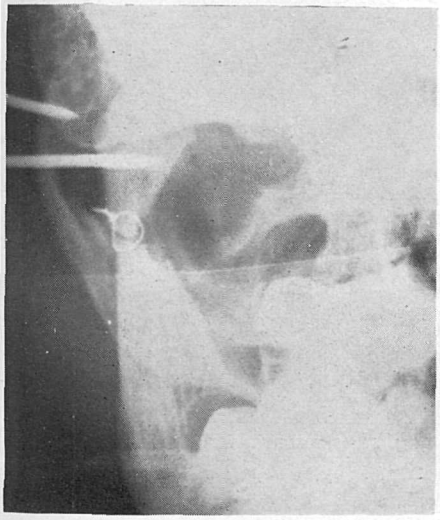

Fig. 6.—Post-operative X-ray showing wiring supplemented with pin fixation in condyle and zygomatic arch.

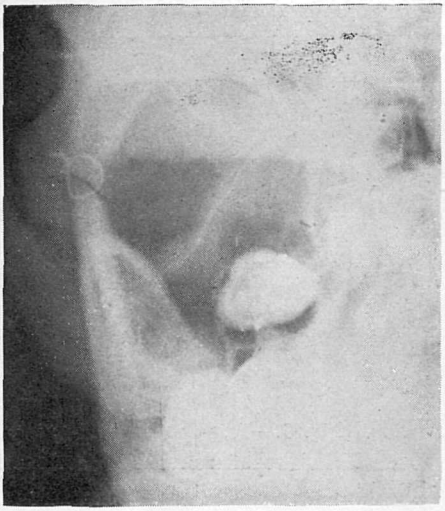

Fig. 7.—X-ray after removal of pins.

CASE OF MANDIBULAR PROTRUSION.

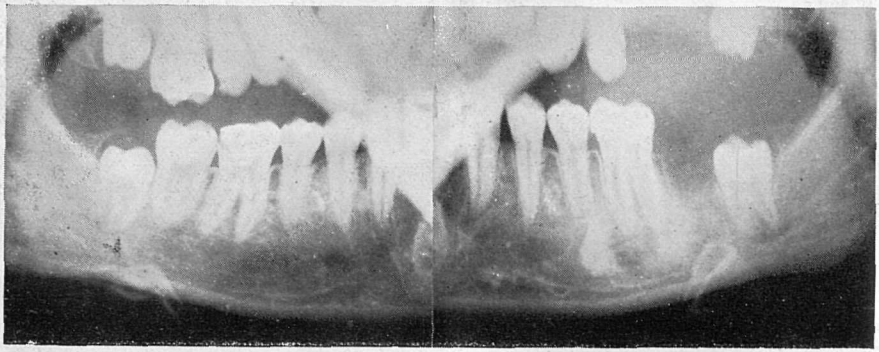

Fig. 8.—X-rays showing absence of second and unerupted third molar.

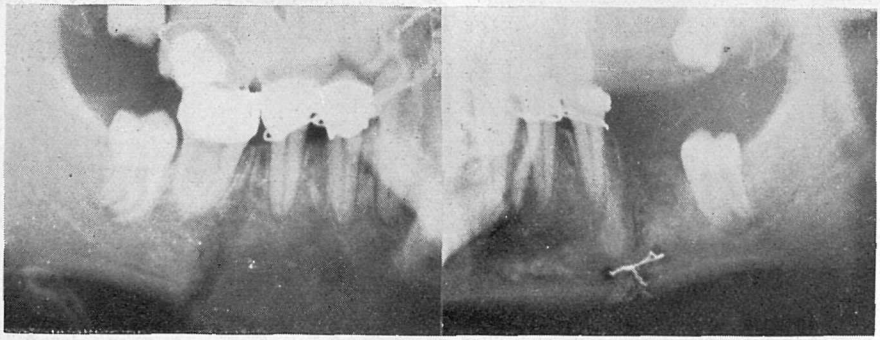

Fig. 9.—Post-operative X-rays showing trans-osseous wiring of posterior edentulous fragments.

CASE OF APER OGNATHIA.

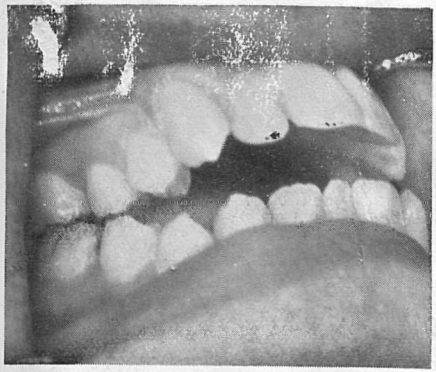

Fig. 10.—Open incisor bite.

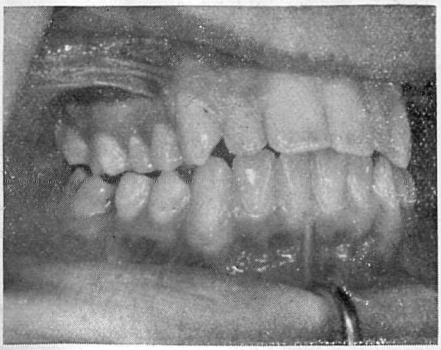

Fig. 11.—Post-operative result.

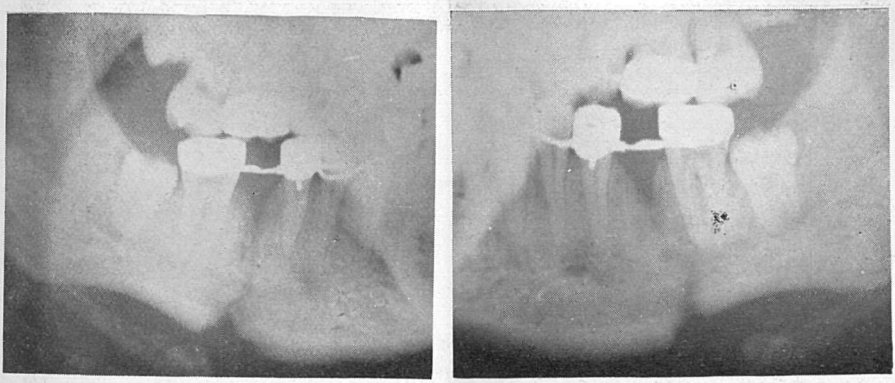

Fig. 12.—Post-operative X-rays.

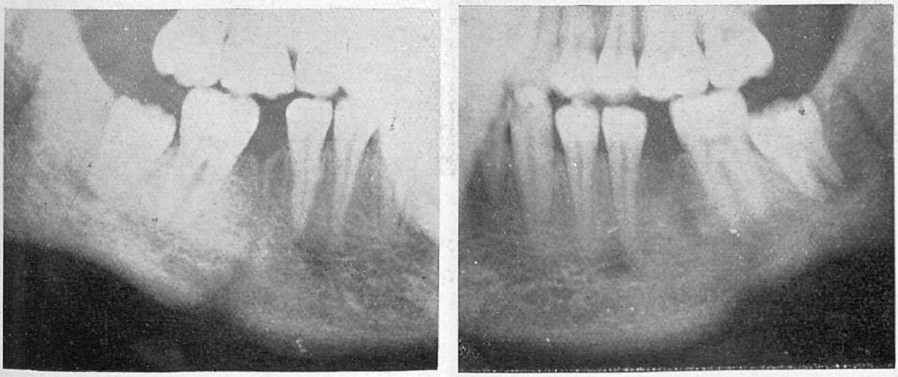

Fig. 13.—X-rays showing healing of ostectomy site.

CASE OF RETRUDING CHIN TREATED BY GENIOPLASTY WITH TANTALUM GAUZE.

Fig. 23.—Before operation.

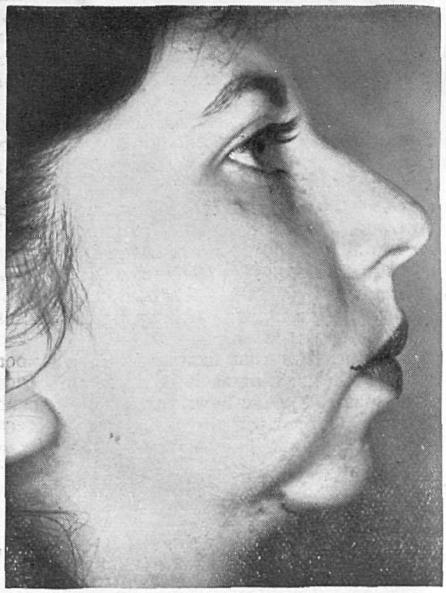

Fig. 24.—After operation.

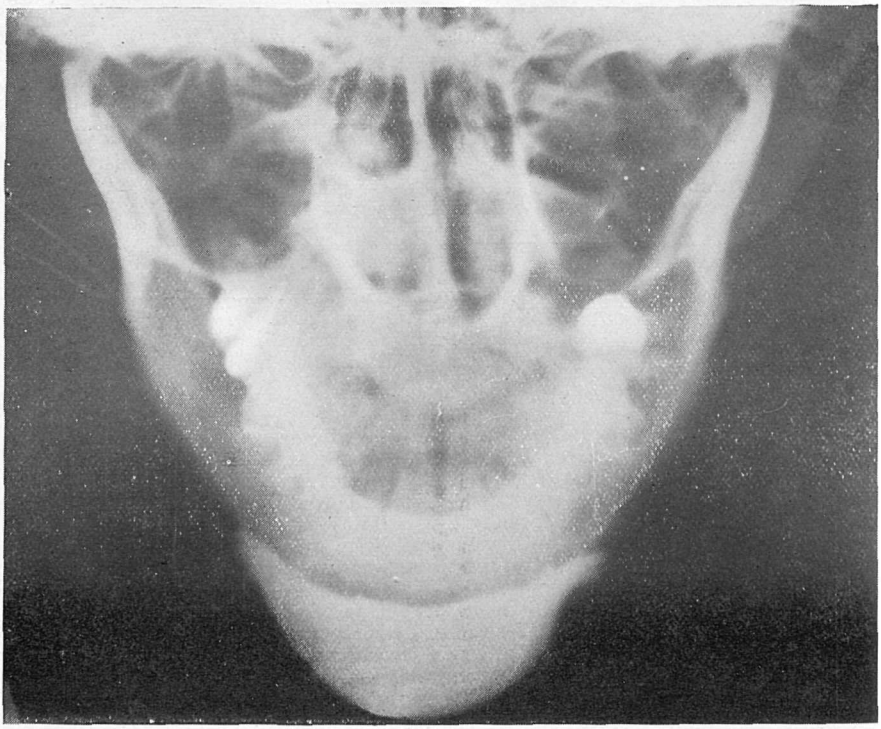

Fig. 25.—X-ray showing inserted tantalum to replace the absent mental protruberance.

scars; to leave a large scar on the lower border of the jaw of course does not improve the patient's appearance. (2) The operation may be done extra-orally, and (3) a combined operation may be done, the oral part consisting of the extraction of the teeth and excision a little fragment of bone over the mandibular nerve which is done first, and then, either at the same time or later on, approaching the same site from underneath by means of an incision below the jaw and locating the two cuts, the rest of the section of bone is removed.

The question is: What is one to do about the inferior alveolar nerve or artery? Should one cut it? It is not difficult to preserve both structures, if first the superior part and then the inferior part of the bone is removed, by splitting it in the middle. A little cavity must be made in the spongiosa of the bone in order to tuck in the extra piece of nerve that extends from one fragment to the other. It is not so easy to do that, however, because sometimes the fragments slip a little and before we know it we impinge on the nerve and produce an anæsthesia of the lip and teeth by pressure. If the nerve is cut completely at both bone incisions, it will regenerate in a very short time—in between two and four months, as a rule. In other words, the neurons in the posterior segment will grow forward into the nerve sheath of the anterior segment, and the lip will regain sensation.

We consider that fixation is quite important, but in the horizontal portion fixation is not as important as it is if the operation is done in the ascending ramus. In the ascending ramus we have, first of all, difficulty in getting contact between the fragments, and this contact is easily lost during recovery from the anæsthesia. Then we get muscular trismus, which has a tendency to cause an over-riding. This muscular trismus is of considerable force and likely to cause an open bite if the anterior fragment is not properly immobilised. Even when the occlusion is apparently good we still need, after removing the appliance for fixation, to prevent open bite by means of elastics for at least 12 or 14 weeks after operation. In the case under discussion I show you a picture of the result. You will observe that the man has a perfectly good facial appearance and no scar whatever, and he has also perfect function and sensation.

The next case is that of a patient with a similar type of protrusion without open bite. The next slide shows the bone being cut out. The approach is from the side. Two vertical incisions are made in the gingiva right down to the inferior border, and in most cases this exposes the entire surface of the jaw so that one has perfectly good vision during the operation.

Next we see a young lady presenting a similar problem. You will observe her very poor occlusion. We generally make plaster models in these cases to see how the teeth will fit together. In most cases we have to do some minor adjustments by grinding of cusps of the teeth. This particular patient had on one side no second molar and an unerupted third, so there was no possibility of intra-oral fixation on the side on which the molar tooth was missing (Fig. 8). The fragment was taken care of by intra-oral incision, drilling two holes, inserting a stainless steel wire which was twisted together after proper positioning of the bones (Fig. 9). Then the small incision was closed with sutures. You will see from the next photograph that the appearance of this young girl has quite considerably improved.

The next is another patient but with a different problem. This patient has a mandibular protrusion and an open bite at the side, projecting in the first molar region. The first molar was lost. I do not consider the loss of a molar very serious, because in most of these cases the third molar will come in, and the patient will have sufficient occlusion. I show the X-ray view in this case to indicate exactly the procedure which was carried out.

APERTOGNATHIA—OPEN BITE.

The boy who figures in my next example was one of my early cases before the war and before the advent of antibiotics, and this is the only case in which I ever had any trouble with infection. The infection was not very serious, but for a few days there was some draining. The intra-oral and extra-oral approach were used. The main problem was an open bite (Fig. 10). This boy wanted to enlist in the American Air Corps, and he was refused on account of his dental abnormality. Therefore he underwent the operation. In this instance again the first molar was extracted. It was necessary to close the bite without shortening the jaw, because I did not want to give him a retruding jaw. (Here again Prof. Thoma, with the aid of a diagram slide, described the manipulations). The operation was performed both intra-orally and extra-orally, after which the anterior teeth were brought into occlusion and locked on the lugs that had been placed on the appliance, attached previously. The post-operative X-ray is shown in Fig. 12, and another taken five months later shows how nicely the bone has filled in (Fig. 13). There is complete occlusion. When the lad went back to be examined for entrance into the Air Corps they made him hang by his teeth on a

rope because they could not believe that his jaw was really solid! He made the grade and had a very good jaw during the war. I show his occlusion as it was when I saw him just before he went into the Service.

The next is the most interesting case I have. The man has an open bite when his posterior teeth are in occlusion (Fig. 14). This patient had a cleft palate and hare lip with the usual dental abnormalities that are associated with such conditions. He had a tooth extracted and had some work done to improve the occlusion. Then he went to an oral surgeon for an operation performed in order to close the bite. The operation was performed in the ascending ramus. Excellent results may be obtained when that operation is properly done in case of mandibular protrusion, but you cannot try to correct an open bite with it, because when you close the bite after the osteotomy in the ascending ramus has been carried out you naturally cause a destraction of the fragments in the ramus. Also, the muscles are placed under additional tension, so that everything works against one. Even if the intermaxillary fixation is adequate the action of the elevator muscles tends to reproduce the deformity as soon as the appliance is removed. Fig. 14 shows the result two years after the operation which was very unsatisfactory. After attaching the appliance for intermaxillary fixation (Fig. 16) the operation was performed in the horizontal ramus. On both sides in the space between the premolar and molar a trapezoid piece of bone was excised. After bringing the fragments into contact and setting up the inferior part an excellent result was obtained (Fig. 15). You will remember that the patient had a cleft palate and hare lip. Though this had been operated with satisfactory result, it was not possible, because of the dental abnormalities, to give him a perfect occlusion. He had a denture made and the result was quite satisfactory.

Mandibular Retrusion.

The opposite abnormality, namely, mandibular retrusion or under-development, is more difficult to deal with. First of all this condition is associated in most cases with ankylosis of the jaw. The characteristic feature of this deformity when acquired in early life is that of an under-developed mandible. I have always felt that the ankylosis was causing this under-development because of the lack of muscular activity. I thought it was mastication which promoted the growth of the jaw, but Professor Rushton has written an article in which he has pointed out that the condylar development—that is, the catilaginous apposition on the condyle—is the main feature in the forward growth. My last case will demonstrate that he is right. In mandibular retrusion the problem of course is not only to lengthen the mandible but also to mobilise the jaw. This can be done in several ways—by an osteotomy in the neck of the condyle followed by insertion of fascia lata, or an osteoarthrotomy with removal of the condylar head. I prefer the latter.

I now present a patient with a unilateral ankylosis, which was acquired at birth. He weighed 14 pounds at birth, and the delivery was extremely difficult. Forceps were used and apparently the condyle was injured. The X-ray picture shows the ankylosis. Recently the patient, now 36 years old, had lost all his teeth because they had become decayed, and his dentist thought they should be extracted. It would have been much better if some of them had been saved. The next picture shows the profile of the patient (Fig. 18). At the operation the condyle was exposed from the posterior direction, and then an osteotomy was performed. The condyle was removed in the manner shown in this series of slides, leaving a large hole which was filled with oxydised cellulose which prevents bone formation. (A series of slides showed the details of the operation). In preparation for a second operation a splint was made for the jaws from a plaster model, on which was made the necessary correction. Then a sliding osteotomy was performed in order to lengthen the jaw. The osteotomy was performed again by means of drills (Fig. 19). The incision was made below the lower border of the jaw. It was necessary to tie the maxillary artery and facial vein. The next picture shows the wire inserted to hold the two fragments in position (Fig. 20). The splint was inserted and attached to the mandible by means of a circumferential wire (Fig. 21). You will see from the portrait of the patient before operation that he had asymmetry as well as a receding jaw, and another view shows him after the correction has been done. In the final result the osteotomy is shown to have healed, and Fig. 22 shows the patient after his dentures have been made and put in position.

Tantalum Plasty to Restore Chin.

We have two more cases in which the patient had a similar mandibular deformity. It was not possible to gain enough improvement of the chin by means of a sliding osteotomy. As a matter of fact, a sliding osteotomy could not be performed in one because she had a cyst in one side of the jaw. Her ankylosis had been successfully cured by an operation some years ago. Instead of doing a sliding osteotomy I improved

her appearance by means of a tantalum graft. This is not sheet tantalum such as you have seen for cranial defect; but tantalum gauze rolled into a sausage-like structure, shaped so as to restore the normal soft tissue contour of the chin. Tantalum is the most inert metal that we possess, fibroblasts grow right through it, and the whole thing incorporates itself into the tissues so that one can hardly take it out later on. The gauze in the ordinary case is simply sewn to the periosteum with a tantalum suture to hold it in place. The final result was a great improvement obtained in the chin.

My last case is extremely interesting. I sent the radiographs of it to Professor Rushton because I thought it was unique. When I first saw the patient I thought it was an ankylosis case with under-development of the mandible. The X-rays showed that the head of the condyle was missing. I could only deduce that she had had a congenital absence at least of the cartilaginous part of the condyle, and because of this absence, according to Professor Rushton's theory, the mandible failed to develop in the usual manner, in spite of the fact that this patient had always been able to eat her food as well as anybody else. It was not lack of muscle activity that produced this deformity but absence of condylar development. In the antero-posterior view you will observe the bilateral under-development of the condyle. I am just keeping my eye on the patient in case something is going to happen. The only rectification she needed concerns the under-development of the chin which probably is due to the under-development of the cartilaginous part of the mandible. Again in this case I have used a piece of rolled-up tantalum gauze. The necessary incision should be made well down on the neck, because when dissecting upwards in order to expose the chin and place the tantalum one must be sure that there is enough tissue to cover the tantalum without bringing the incision and later the scar into view. It should be in the shadow of the chin.

I show a portrait of the patient before and after the operation (Figs. 23 and 24). It illustrates the improvement of the chin. I have X-rays taken immediately after the operation and eight months later the tantalum implant looks exactly the same, the gauze remaining as it was when it was put in, becoming incorporated into the connective tissue (Fig. 25). It is quite extraordinary what can be done with this material.

Guy's Diary

November — **ACADEMIC**

Exhibition. Surgical Department. "Obstructive Jaundice."

7th. 1.00. Mr. Morgan. Clinical Lecture.
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
8th. 1.00. Mr. Marston. Clinical Lecture. "Anæsthesia in the Dental Chair."
9th. 4.45. Guy's Science Club. Professor R. H. S. Thompson, D.M. "The Cholinesterases of Mammalian Tissue." Staff Common Room. (Tea 4.30).
10th. 4.30. X-ray Demonstration. Gordon Museum.
11th. 1.00. Dr. Hardwick. Clinical Lecture.
2.15. Medical Department. Combined Round. Preclinical Classroom.
12th. 10.00. Mr. Ralph Marnham, St. George's Hospital. Surgical Departmental Round. Clinical Th.
14th. 1.00. Major-General Sir Alexander Biggam. Clinical Lecture. "Tropical Diseases."
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Department of Child Health. Film Show. Anatomy Theatre.
15th. 12.00. Medical Department. Neurological Demonstration. Preclinical Classroom.
1.00. Major-General Sir Alexander Biggam. Clinical Lecture. "Tropical Diseases."
16th. 1.00. Major-General Sir Alexander Biggam. Clinical Lecture. "Tropical Diseases."
17th. 12.00. Mr. J. W. Mansie. Dental Clinical Lecture. "Pain." Dental Theatre.
1.00. Major-General Sir Alexander Biggam. Clinical Lecture. "Tropical Diseases."
4.30. X-ray Demonstration. Gordon Museum.
18th. 1.00. Major-General Sir Alexander Biggam. Clinical Lecture. "Tropical Diseases."
2.15. Medical Department. Combined Round. Preclinical Classroom.
21st. 3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

November — **OTHER ENGAGEMENTS**

8th. 5.00. Dental Society. Mr. H. G. Carr. "A Visit to Scandinavian Dental Schools."
9th. Rugby XV. *v.* Cambridge University. (H.O.P.).
Association Football—2nd XI. *v.* Bristol University. (H.O.P.).
10th 7.00. Physical Society. Massage Gym.
12th. Rugby XV. *v.* Birkenhead Park. (Birkenhead).
Association Football—1st XI. *v.* University College. (Away).
Hockey 1st XI. *v.* Gravesend. (Away).
Hockey 2nd XI. *v.* Gravesend. (H.O.P.).
15th. 4.30. Students' Union. Annual General Meeting. Physiology Theatre.
5.00. Dental Society. Mr. E. G. M. Stillwell. "Inlay Investments."
16th. Association Football—1st XI. *v.* University College Hospital. (H.O.P.).
Rowing—United Hospitals' Regatta (Thames R.C., Putney).
18th. 8.00. Dental Society. Annual Ball. Grosvenor House, Park Lane.
19th. Association Football—1st XI. *v.* Old Latymerians. (H.O.P.).
Association Football—2nd XI. *v.* Old Latymerians. (Away).
Rugby XV. *v.* Rosslyn Park. (Old Deer Park).
Hockey 1st XI. *v.* R.N.C., Greenwich. (H.O.P.).
Hockey 2nd XI. *v.* Spencer. (Away).
21st. Rugby XV. *v.* University College, Dublin. (H.O.P.).

Correspondence

The Dental Dinner

SIR,—Soon many old Guy's men will be looking forward to the Dental Dinner. Many will I am sure regret with me its changed character.

I am all for fun and games, let us have bigger and better balls and dances; let us have fancy charades and kiss-in-the-ring, but do the ladies really like coming to a Dinner?

Will the getting older Guy's men travel half across the country except to a Stag Party?

Yours, etc.,

"HAPPILY MARRIED."

London, W.1.

Old Guy's Week

SIR,—It was a real joy to read, in this morning's *Gazette*, your suggestions for an "Old Guy's Week."

Could it be within the next six weeks, before the busy season begins? I would do my level best to come.

With kind regards and many thanks for the great help and comfort of the *Gazette*.

Yours, etc.,

JOHN H. CHITTY.

Bronheulog,
Llanrhaiadr,
Oswestry.

Obituary

S. H. CROUCHER.

IT is with deep regret that we announce the death of Mr. Samuel Henry Croucher, J.P., who died suddenly on Thursday, October 27th.

Mr. Croucher was born in 1865, joined the administrative staff of the Medical School on August 22nd, 1888, and in July, 1895, was appointed Clerk to the Dean of the Medical and Dental Schools, a post he held until his retirement in 1925.

When Mr. Croucher first came to Guy's there was no Dental School, College or Clubs' Union, and during his period of service the Schools rapidly expanded.

The posts he held for so long at Guy's always meant very hard work. However, it did not seem that this work alone provided anything like a sufficient outlet for his energies, for when quite a young man he threw himself heart and soul into the public life of Penge, the district where he lived practically the whole of his life.

For many years he served on the Penge Council, of which he was Chairman from 1922–23, and in 1927 was appointed a Justice of the Peace. During his service on the Council, Mr. Croucher devoted himself specially to the problems of education, public health, housing and infant welfare. He served as chairman on a number of these committees, was mainly responsible for the introduction of the Maternity and Child Welfare Clinic which has done such good work in the district and took a leading part in the formation of the School Dental Clinic.

Mr. Croucher was also a regular worshipper at the Penge Tabernacle and in turn held the offices of Deacon, Elder and Church Treasurer for many years.

His capacity to combine a loyal, devoted and highly efficient service to Guy's with multitudinous duties outside, the consideration he showed to students in his dealings with them and the keen interest he took in Guy's men after they had qualified, were perhaps the most appreciated of Mr. Croucher's many qualities. Mr. Croucher will be mourned by many Guy's men and our deepest sympathy is extended to his son, Mr. H. V. Croucher, who qualified from Guy's in 1920, and two daughters who survive him.

J.H.E.W.

Sport

ASSOCIATION FOOTBALL

FIRST PRELIMINARY ROUND A.F.A. SENIOR CUP

Guy's *v.* Gt. Western Railway

At H.O.P. Won 4—2.
22nd October, 1949.

Guy's having suffered the temporary loss, through injury, of their two inside-forwards anticipated a hard game.

The Railway XI pressed keenly from the opening minutes of the game, and were soon rewarded with a goal from their left-wing, a curling shot into the far corner of the net. This appeared to stimulate the Guy's attack and the game moved from one end of the field to the other, but the score remained unchanged at the interval. Guy's were for the latter part of this half playing one short, a victim of new boots.

The second half opened with the Guy's attack, amongst whom Sturdy was prominent, moving with more determination towards their opponents goal. But it was only after fifteen minutes of the second half had passed that their efforts were rewarded. An attack by the Railway on the Guy's left flank was effectively halted by Bishop, who cleared strongly across the field, immediately opening the game up. Cornhill quickly pounced on to the ball, controlled it, then placed a fine shot past the Railway goalkeeper.

Then followed the decisive moments of the game. This goal inspired the Guy's attack to greater efforts, and two more goals were quickly added. A Matthews pass to Harris initiated the first of these. Harris flicked it to Sturdy whose hard shot found the back of the net. Sturdy nodded in the next from these now regular Cornhill centres.

We were by this time again at full strength. The lead was increased still further by yet another Sturdy goal. At this point the home team eased up but were shocked into action by a break through from the Railway attack, the ensuing shot giving Fearn no chance.

Outstanding in defence were Bishop, for his long clearances, and Matthews who started many attacking movements with his intelligent passing of the ball.

Team : A. Fearn ; D. Lipington, M. Bishop ; D. Matthews, D. Allen, A. Swift ; B. Cornhill, E. Newton, D. Harns, E. Sturdy, P. Holloway.

SOUTHERN AMATEUR LEAGUE

Guy's *v.* Alleyn Old Boys

At H.O.P. Won 4—2.
29th October, 1949.

The Hospital side maintained their unbeaten record for the season and brought their tally of league points to seven out of a possible eight. The first twenty minutes saw Guy's continually pressing the Old Boys' defence and in this period scored two goals, the first being in the nature of a classic. Cornhill on the right wing collected a long pass, beat the full-back and centred accurately on to the head of Sturdy who had positioned himself by the far post, the left winger making no mistake. The second was a typically opportunist effort by centre-forward Harris who beat the centre-half in a race for the ball and placed it in the far corner of the net. The Hospital side seemed to slacken off a little after these initial successes and the visitors opened their account by converting a free kick, awarded on the edge of the penalty area for an obstruction infringement by a Guy's defender. Half-time came with the score 2—1.

On the resumption of play the home side quickly drew further ahead with a first-time shot by left-winger Sturdy. This same player headed the ball into the net a few minutes afterwards but was adjudged off-side. However the Alleyn supporters in conjunction with the Guy's supporters witnessed the finest shot seen at H.O.P. for many a long day when Prince banged the ball into the net from 30 yards out. The visitors collected their second goal near the end, after a long dribble by Lipington was rudely interrupted and the ball pushed out to the unmarked winger who had a clear run to goal. Even so his shot should have been stopped by Fearn who, however, was only able to parry the shot and it then continued into the net.

Team : Fearn ; Lipington, Vaughan ; Matthews, Allan, Swift ; Cornhill, Newton, Harris, Prince, Sturdy.

HOCKEY

On 22nd October, for the first time since the war, Guy's turned out four teams. The majority of the fourth eleven were newcomers to the Hospital. In spite of their defeat they enjoyed the game and with practice should soon be giving a good account of themselves. There is, as yet, no fixture list for the fourth eleven but if members will tick their names off by Wednesday and if sufficient numbers are available, a game can be arranged for the Saturday of the same week. The membership of the club exactly permits of the playing of four teams a week.

Of the first eleven's game against Barclays Bank little need be said. Blake and Robinson played good hockey and Meyers' determined efforts to penetrate Barclay's defence deserved the reward of a goal. Barclays scored the only goal of the first half. Blake equalised for Guy's and the winning goal came from a first-time shot by Barclay's inside left. It was a good game, enjoyed by both sides and the entertainment after the game was all that could be desired.

Team : First XI.—F. H. Walker ; G. H. Danford, H. Carter ; C. Robinson, E. A. Murray (Capt.), W. Dobson-Smyth ; A. Blower, D. E. Blake, L. L. Emery, H. Meyer, R. Hodson.

Results :

Guy's 1st *v.* Barclay's Bank 1st	.. Lost	1—2.
Guy's 2nd *v.* Barclay's Bank 2nd	.. Draw	0—0
Guy's 3rd *v.* Barclay's Bank 3rd	.. Lost	0—1
Guy's 4th *v.* Cheam 5th	.. .. Lost	2—14

GOLF

Dental Staff *v.* Students

At Sundridge Park Golf Club.
19th October, 1949.

Staff.		*Students.*	
J. W. Mansie ..	1	D. M. Griffiths ..	0
R. J. Wheatley ..		J. M. D. Grant ..	
G. S. Loader ..	0	D. E. Blake ..	1
W. S. McConnell		W. D. Flynn ..	
M. Malleson ..	0	J. Mepsted ..	1
J. R. Dyer ..		A. W. Baker ..	
H. Richards ..	1	N. J. Mayson ..	0
B. Donner ..		W. H. Garland ..	
	2		2

The weather was very kind and the course was in excellent condition, so after the question of strokes had been amicably settled an early start was made. In the first match, Mr. Mansie and Mr. Wheatley proved a strong combination, having nett twos at no fewer than three holes. Mr. Donner, whom we were pleased to welcome as a newcomer to the Staff team, was in great form and ably supported by Mr. Richards won their second match to make the very satisfactory result—Staff 2, Students 2.

We would like to take this opportunity of expressing our very many thanks to the staff and especially to Mr. Mansie and Mr. Wheatley for giving us such an enjoyable fixture.

J.M.D.G.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the post of **Senior Registrar** in the **Radiotherapy Department.** It is desirable that candidates should hold a Higher Qualification in Surgery or Medicine, or a Diploma in Radiotherapy. Salary in accordance with Terms and Conditions of Service of Hospital Medical Staffs, *i.e.* £1,000 per annum. Application forms are obtainable from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, and should be forwarded with the names of three referees not later than 29th November, 1949.

Applications are invited for the appointment of **Registrar, 1st year,** to the **Evelina Hospital** for Sick Children, Southwark Bridge Road, S.E.1. Commencing date early in the New Year, 1950. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be forwarded to him not later than 22nd November, together with the names of three referees.

York Clinic for Psychological Medicine, Resident House Physician. Applications are invited from qualified medical practitioners who wish to take the D.P.M., for the post of **Resident House Physician** (two vacancies); duties to commence on December 15th, 1949. The appointment will be for six months in the first instance, and may be renewed for further such periods. Salaries of the posts will be in accordance with the Terms and Conditions of Service for House Officers in the National Health Service. Applications, accompanied by copies of two testimonials, should be sent to the Superintendent, Guy's Hospital, London Bridge, S.E.1, not later than November 30th, 1949.

DENTAL SOCIETY ANNUAL BALL

Guy's Hospital Dental Society Annual Ball will be held on Friday, 18th November, at Grosvenor House, Park Lane, W.1, from 8 p.m.–1 a.m. Tickets, price 25*s.* single, may be obtained from the Hon. Secretaries :—

G. F. THOMPSON.
G. V. CRINE.

HOCKEY CLUB DINNER

The Hockey Club Dinner will be held on November 24th, at 7.0 p.m., in the King's Head in Newcomen Street. All past and present members of the Club will be cordially welcomed. Tickets 12*s.* 6*d.* obtainable from the Hon. Secretary.

Any old members interested in a "Past and Present" match, to be held the same afternoon, should communicate with the Hon. Secretary.

STUDENTS' UNION

The Annual General Meeting of the Students' Union will be held on Tuesday, November 15th, at 4.30 p.m., in the Physiology Theatre.

HOUSE APPOINTMENTS

Applications are invited for the following House Appointments at Guy's Hospital; duties to commence on December 1st, 1949 :—

Assistant House Surgeons	(5)
Out-Patient Officers	(4)
House Surgeons	(2)
House Physicians	(4)
Children's House Physician	(1)
Dermatological House Physician	(1)
Genito-Urinary House Surgeon	(1)
House Surgeon to Thoracic Unit	(1)
Throat and Ear House Surgeon	(1)
Ophthalmic House Surgeon	(1)

Applications are also invited for the post of :—

House Physicians in the York Clinic Commencing 15.12.49.	(2)
Resident Obstetrician Commencing 1.1.50.	(1)

In future, the salaries of all posts will be in accordance with the new Terms and Conditions of Service, as follows :—

£350 per annum for the first six months.
£400 „ „ „ „ second six months.
£450 „ „ „ „ third and any subsequent period.

A deduction at the rate of £100 per annum will be made for board and lodging.

The Medical Committee will also consider applications for appointments at the County Hospital, Orpington; the County Hospital, Pembury; Joyce Green Hospital, Dartford; and the Southern Hospital, Dartford, and will nominate candidates for posts at these Hospitals, to commence on December 1st, 1949.

Applications, giving choice of post and choice of Hospital in order of preference, should be lodged in the Superintendent's Office not later than Wednesday, November 9th, 1949; in the case of applications for House Physician, York Clinic, these should be received not later than November 30th, 1949. Candidates who apply for appointments at Guy's as Assistant House Surgeon, House Physician or House Surgeon, should indicate their preference for Firms.

BIRTHS

DENNY.—On October 26th, 1949, in Guy's Hospital, a son to Pauline Denny, S.R.N., S.C.M. (née McEntegart), wife of Douglas Denny, B.Sc.

SCOTT.—On October 31st, 1949, at Nuffield House, to Esmé (née Pascall), wife of Dr. Leslie Scott—a son (Christopher Gordon).

DEATHS

CROUCHER.—On October 27th, 1949, Samuel Henry Croucher, J.P., Clerk to the Dean of Guy's Medical School, 1895–1925, of 11, Thornsett Road, Anerley, S.E.20.

EASON.—On November 2nd, 1949, Sir Herbert Lightfoot Eason, C.B., C.M.G., M.D., M.S., F.R.C.S., President of the G.M.C., of Newbridge Mill, Coleman's Hatch, Sussex.

KYLE.—On October 8th, 1949, James Kyle, Air Commodore R.A.F. (retired), Brendon, Wendover Bucks.

Eds. { R.G. P.A.Z.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

THE memorial service to Sir Herbert Eason was held in the Hospital Chapel on Friday, 11th November. The Reverend W. Denys Giddey, resident chaplain, officiated at the ceremony, being assisted by the Provost of Southwark Cathedral. Mr. W. M. Mollison delivered the address, the substance of which he has kindly contributed as an obituary notice which appears on another page of this issue.

A very large number of people, representative of the Hospital, the University and the medical profession generally, chose the occasion to pay tribute to one who was distinguished not only in his particular specialty but even more so as an administrator and as a man. To place in such close relationship the capacity of Sir Herbert as an official with his excellence as a person may seem incongruous, particularly in these days when one thinks of " the anti-bureaucratic feeling which now exists in this country." But, we suggest, it is those very qualities that constitute the humanist and the liberal mind that are in greatest demand for those who are entrusted with authority over others. He who was so successful as Dean of the Medical School, Superintendent of the Hospital, Vice-Chancellor of the University and President of the General Medical Council was by no means a slave or devotee to system and regulation for its own sake. He recognised, none the less, that even the work of the physician and surgeon called for some guidance, both clinically and ethically, and that if " the cure for anarchy is a hierarchy," to use John Buchan's words when writing of Augustus, certain principles governing the conduct of affairs must be " administered."

To-day the health services of this country are in a phase of rapid evolution—one might almost say convulsion. Total expenditure has exceeded all estimates. Critics abound and suggestions are profferred in confusion. As an editorial article in the *Lancet* quoted with much pertinence a month or so ago " a country can have only the standard of living it can pay for; and that standard of living includes the National Health Service as one of its components, but only one, and not one with an over-riding priority." With a yawning and persistent " dollar gap " the scope of the national budget must be severely curtailed and any reductions that are put into effect will surely include the medical services. Economies, however unpleasant, will be forced on Regional Hospital Boards, on Management Committees and the like. Their putting into effect will call for the utmost wisdom and tact. Only by the endeavours of the most competent administrators will these troublesome times be survived.

The argument, meanwhile, goes on. With a great deal of acrimony men argue about salary and preferment—specialists vie with family doctors, consultants vituperate on the subject of distinction awards, " medical officers " feel unkindly disposed towards practitioners. Personnel may be lacking to fill certain important posts in the profession but none is in so great a demand as the really effective and esteemed administrator. We suggest that suitable incumbents for these otherwise despised positions should be sought, established and given adequate reward.

Guy's, as Mr. Mollison commented, has been well and loyally served by its officers over the course of two centuries. Amongst them, Sir Herbert Eason was a brilliant and worthy member. So long as the Hospital can number among its alumni such as he, " possessed of the major virtues which Aristotle enumerates, but especially *φρόγησις* " we can be sure that the medical service of this country will not fail for lack of leaders any more than it will suffer from a dearth of clinicians and associated workers.

Obituary

HERBERT LIGHTFOOT EASON, Kt., C.B., C.M.G., M.D., M.S., F.R.C.S.

GUY'S and its Medical and Dental Schools have sustained a great loss in the death of Sir Herbert Eason; he did splendid work not only at Guy's but in many responsible positions in the Medical world.

Eason came to Guy's from University College and qualified in 1898, took the M.D. of London in 1901 and the M.S. London the following year, thus marking himself as an outstanding student. He became attached to the Eye Department, assisting those two notable members of the staff, Dr. Brailey and Mr. Higgens.

He was appointed Dean of the Medical School in 1904, an unusual honour for one not on the staff; in this post he followed Dr. Fawcett.

A year later Eason was elected Assistant Ophthalmic Surgeon and in 1906 became Senior Surgeon in the Department, which he conducted with skill and enthusiasm and soon made his value felt; he never allowed other duties to interfere with punctual attendance in Out-patients and Wards; his lucidity of thought and clinical acumen gave him a broad outlook, most valuable in any specialty; his teaching both clinical and academic in the form of lectures made him justly popular with students; this opinion was much appreciated when in consultation with colleagues. He was an active member of the Ophthalmological section of the Royal Society of Medicine; he did not write much, but contributed the chapter on his subject in French's Index of Differential Diagnosis and one or two articles in the Guy's Reports. During the 1914–18 War he served as Consulting Ophthalmic Surgeon in Egypt with the rank of Lt.-Colonel, and his professional knowledge and organising ability were greatly valued and put to good use. He was awarded the C.M.G. in 1917 and the C.B. in 1919.

There is little doubt that he would have risen to the highest place in Ophthalmology had it not been for the many other interests thrust upon him.

Eason was Dean for eight years; during this time the School had embarked on a scheme of expansion and re- building for the carrying out of which the Dean was largely responsible through the School Council. Eason proved more than equal to this task; he had a strong personality, a clear and penetrating mind. He was insistent on the proper use of words and their precise meaning, all invaluable qualities for conducting committees; he spoke well and incisively.

During his tenure of office two floors were added to the School building and many structural alterations effected.

From 1911 he was intimately associated with London University, he became representative of the Faculty of Medicine on the Senate, was a member of the University Court, and served on many important committees. From 1935 to 1937 he was Vice-Chancellor and later occupied the exacting position of Principal for four years during which time the tower of the vast building was completed; a quietly humorous colleague used to refer to the block as "Eason's flat."

There can have been few who could see through the intricacies of the regulations of London University, but Eason was amongst those few.

In 1920 he succeeded Sir Cooper Perry as Superintendent of the Hospital, and ably upheld the high standard of efficiency set by Sir Cooper who had an acknowledged genius for administration.

The Superintendent occupies the most prominent position in the Hospital and finds himself the focal point of all its activities with every aspect of which Eason quickly became familiar; he enjoyed intimate knowledge of the work of all branches of his extensive Lay staff from Almoners to Carpenters; he was always ready to discuss the several problems that arose in all parts of the Hospital and solved them, and his fairness and instinctive good judgment were recognised by all.

His life of responsibilities conduced to a serious mien which gained for him a reputation for being unapproachable; with friends, however, he could and did relax and no one enjoyed reunions more than he, an admirable conversationalist with a fund of witty stories. Entertaining was a pleasure to him and many generations of House Officers enjoyed the charming hospitality of Mr. and Mrs. Eason in the beautiful house adjoining the Court Room, destroyed by fire in an air-raid. At the age limit he retired in 1937; all sections of the population working at Guy's joined in expressions of praise for all he had done and in wishing him all happiness in his retirement.

Eason had been a member of the General Medical Council since 1925 and in 1939 he was elected its President, perhaps the most important and onerous positions in administrative Medicine. He conducted the business with effortless distinction. In disciplinary cases he tempered justice with mercy. He retained this position till his death.

In 1943 he was knighted.

Among other distinctions he was a J.P. and an honorary Bencher of the Inner Temple, and represented the Ministry of Health on the General Nursing Council.

In 1908 he married Hon. Irene Bingham who died in 1917; they had one daughter; in 1920 he married Miss Wallace and they had two daughters.

To his widow and daughters we offer our deepest sympathy.

W.M.M.

Colonel E. G. S. Waley writes :—

Many are better qualified and entitled to write an appreciation of Sir Herbert Eason than myself; my only excuse for doing so is an unbounded admiration for him and all his works and the privilege of close association with him, and of his personal friendship over a long number of years.

This association dates from the period in the first World War when he commanded the 21st General Hospital at The Citadel in Cairo. Holding an appointment of minor importance on G.H.Q. staff I had many occasions when his ability and tact as an administrator were made clear to me and when his advice and encouragement were invaluable.

In the post-war years when he took over as Medical Superintendent of Guy's, he did me the great honour of proposing me as a member of the Court of Governors of the Hospital and brought into my life the new interest of voluntary service on behalf of the sick and needy poor which developed into and still remains a cause very near my heart. His love for Guy's, his pride in its achievements and his jealousy of its reputation were the all-absorbing interest of his vital spirit and energy and I am sure, despite the many other distinguished appointments he filled with success, his years as Superintendent were the happiest of his life.

Fearless in his opinions and outspoken in argument, he was nevertheless ever courteous in debate and tolerant of the views of others. If a committee out-voted him, and they generally proved to be wrong subsequently if they did so, he supported their decision and carried out their policy without rancour and with unswerving loyalty.

Truly he represented all that was best in public life and voluntary service, and his loss to his profession in general and Guy's in particular will be grievous.

To those privileged to work with him and enjoy his friendship, the gap left by his passing can never be filled.

Mr. F. N. Doubleday writes :—

Will you allow me to express my sense of the great loss which we have all suffered in the death of Sir Herbert Eason. When I first came to Guy's he was a young man and Warden of the College. It has been a privilege to know him and to work with him for Guy's ever since. He was a true friend to those of us who were in the Dental School; he had not only marked clearness of intellect but also a ready friendship.

Jamaica

Professor G. STEAD.

Physics Department, Guy's Hospital Medical School.

OCTOBER 1948 saw the modest beginnings of an ambitious scheme to found a new University in Jamaica to serve the higher educational needs of the whole of the British West Indies, including British Guiana and British Honduras on the mainland. Until the University College of the West Indies is strong enough to stand upon its own feet it will have what is called a "special relationship" with the University of London, which means in practice that its students will work for London degrees and will take examinations conducted jointly by local internal examiners and external examiners appointed by the University of London. One of the serious problems that has had to be faced is the heavy cost of transporting students between their homes and Jamaica. Both Trinidad and Barbados are some 1,200 miles distant from Kingston, while British Honduras is somewhat nearer and British Guiana considerably further away. As the regular inter-island steamer services of pre-war days no longer exist, all journeys have to be made by air, a mode of travel which is speedy and convenient, but expensive. Owing to the urgent need for more doctors in the Carribean area priority has been given to the Faculty of Medicine, but a Faculty of Science will be created in October, 1949, and a Faculty of Arts in October, 1950. It is proposed to admit 30–40 1st M.B. students each year, so that after six years there will be a complete medical school with some 200 undergraduate members. The first examination for the 1st M.B. was held in July of this year, and I was invited by the University of London to visit Jamaica as external examiner in Physics, and also to report on the progress made in the establishment of the basic scientific departments.

My departure was somewhat delayed by the Avonmouth dock strike, but the difficulty was overcome by moving the ship across the Bristol Channel to Newport from which I sailed on June 3rd. A large crowd of my students, undeterred by pouring rain, very kindly came to Paddington to wish me *bon voyage* and to give me a rousing send-off. I had not anticipated such an ovation, but greatly appreciated the warm and friendly spirit which prompted it. My fellow passengers were much intrigued and wondered what it all meant. There were some 70 of us aboard the S.S. *Bayano*, representing a wide variety of human types, but they were a friendly crowd and always ready for a chat, so that the 15 days voyage passed pleasantly enough. The Atlantic seemed vast and empty, and the daily run of 300 miles or so looked pitifully small on the chart, but at last on the eleventh day we came in sight of land and had the excitement of spending a few hours ashore in Bermuda, an attractive group of low coral islands with a sub-tropical climate and no income tax. It sounds like a paradise, but I was told that the cost of living is high, partly owing to heavy indirect taxation and partly because Bermuda has become a popular holiday resort for the wealthier type of American tourist. After leaving Bermuda we ran into violet-blue tropical seas, alive with flying fish by day and aglow with phosphorescent light after dark. For part of one day we followed the western coast of Hayti, which in that region appeared to be very mountainous and almost uninhabited, and that same evening I saw the Southern Cross for the first time. At last one morning, looking out through my porthole, I beheld the south coast of Jamaica with the Blue Mountains in the background, and knew that I had reached journey's end. I was met at Kingston Harbour by the Vice-Principal and the Head of the Physics Department, and motored straight to the house of the Principal, where I was the guest of Dr. and Mrs. Taylor for the first ten days of my visit.

The University College of the West Indies occupies a magnificent site of 600 acres in the beautiful Mona valley some seven miles from Kingston, with the Blue Mountains rising to a height of 4,000 ft. to the north and a lower ridge shutting off the view of the sea to the south. Temporary wooden buildings, taken over from a war-time camp, have been skilfully adapted for academic purposes. Provision has been made for University Offices, University Library, Dining Hall, College Chapel, and Students' Hostels, and there are also roomy and well-equipped departments of Physics, Chemistry, Zoology and Botany already in use, as well as departments of Physiology and Anatomy which are due to be opened in October of this year. The Heads of all the existing science departments have formulated plans for research and some investigations are already in progress. Jamaica offers splendid opportunities for zoological and botanical research, especially in the domain of marine biology, and some of the important local industries, such as sugar production and fruit canning, are in need of help from the

chemists. Physics is likely to develop on the biophysical side, and to have close contacts with radiotherapy. The only permanent premises so far erected are houses for members of the staff, but the planning of the whole site is now practically complete, and it is hoped that it will be possible to start building operations in the near future. I examined the plans and formed the opinion that, within the limits set by the funds available, the architects have realised to the full the possibilities of the site, and have designed buildings which, both individually and collectively, will be worthy of a great University.

One of the first of the new buildings to be erected will be a University Teaching Hospital, and every effort is being made to have part of this ready by April, 1951, when the first batch of students will enter the clinical period, but it is probable that for a time beds in Kingston General Hospital will have to be used for teaching purposes. The number of beds to be provided in the new hospital is not yet finally decided, but must be sufficient to meet all the requirements for clinical teaching, and is therefore likely to be between 500 and 1,000. Jamaica, generally, is inadequately provided with hospital accommodation, and this often results in terrible overcrowding. I was told that it was not uncommon to find two or even three patients in one bed, and the University Hospital should do something to remedy this shocking state of affairs. Many of the small provincial towns contain institutions of the cottage hospital type, which vary greatly in the extent and efficiency of the service given. I was taken over a new hospital at Port Antonio on the north coast, and found it cheerful, airy and thoroughly modern in its organisation and equipment, but the Medical Superintendent, who was justly proud of it, told me that he could easily fill three times as many beds. In Jamaica there is not only a shortage of hospital accommodation, but also of doctors and nurses, and a preliminary training school for nurses has already been started in one of the huts on the Mona site. The Matron in charge is Miss Foster-Smith, an old Guy's Sister, well-known to many of us here. She told me that two of her assistants are also Guy's trained, and that some 30 Jamaican girls are receiving instruction in readiness for the opening of the University Hospital. She asked me to convey her greetings and best wishes to all her friends at home.

My time in Jamaica was devoted quite as much to sightseeing and social activities as to work, and I shall never forget the warmth of my reception, or the kindness, friendliness and generous hospitality that I received wherever I went. It is my earnest hope that, as the years go by, personal contacts between London teachers and members of the West Indian staff will become more and more frequent, as I am convinced that only in this way can the special relationship between the University of London and the University College of the West Indies be made a real and living thing. During my visit I learned that Princess Alice, Countess of Athlone, has graciously consented to be the first Chancellor of the new University, and has promised to visit Jamaica early next year, thus forging a link with the University of London at the highest level.

During my stay every effort was made to show me as much of the island as time permitted, and I think that I must have motored at least 500 miles altogether. Jamaica is nearly 150 miles long and about 50 miles wide, and the main roads have good tarred surfaces, but, owing to the exceedingly mountainous nature of the country, they are narrow, steep and full of hairpin bends, so that high average speeds cannot be maintained and actual distances are very much greater than they appear to be on a small-scale map. For this reason I was not able to penetrate so far west as Montego Bay, but I traversed the whole of the north coast from Discovery Bay (the traditional landing place of Columbus) almost to Morant Point in the extreme east, and back along the south coast through Kingston to the old capital, Spanish Town. I also made several expeditions into the mountains, but could not spare the two days necessary to make the ascent of Blue Mountain Peak (nearly 7,400 ft.), the highest point on the island. I was told that the view from the summit is magnificent, when there *is* a view, but that more often than not it is obscured by rain or mist. One day I had the unexpected pleasure of seeing Mr. T. B. Layton who, since his retirement from the E.N.T. Department, has taken on the job of ship's surgeon to the " Jamaica Producer," one of the fleet of banana boats. His ship came into Kingston for the week-end, and some of our friends kindly invited us both to a lunch picnic, which we greatly enjoyed. There is a wonderful variety of scenery in Jamaica. Some of the mountains are rugged and covered with scrub in the lower parts, others are typical limestone formations with rounded grassy summits and steep sides clothed with forests for some thousands of feet and showing terraced outcrops of rock at the higher elevations. There are large areas of cocoanut palm and banana plantations, flat low-lying regions devoted to the growing of sugar cane, pastoral tracts superficially very much like England, beautiful river valleys and limestone gorges not

unlike Dovedale, whilst the Liguanea Plain around Kingston is aglow with magnificent flowering trees and shrubs. Most of the north coast is a succession of idyllic bays, each with its beach of white coral sand and palm trees coming down almost to the edge of the intensely blue sea, backed by the mountain range that runs nearly the whole length of the island from east to west. On the south coast east of Kingston there are some interesting salt lagoons and a number of small islands or cays, whilst west of Spanish Town there is an almost uninhabited region of mangrove swamps infested with crocodiles, mosquitoes and other unpleasant things. Outside this region mosquitoes are scarce and give little trouble. The climate of Jamaica is generally good and healthy, and except in July and August neither too hot nor too humid. I understand that the temperature hardly ever rises above 95° F., and that heat stroke is practically unknown.

The population of Jamaica is about 1,250,000, and is extremely mixed. The majority of the people are derived from European stock on the one hand and negro types from Africa on the other hand, and there is a continuous gradation of colour from pure white to pure black, but officially there is no colour bar. There is also a considerable Chinese element, which has captured most of the grocery trade, and a number of East Indians and Syrians. Jamaicans, whatever their colour or social status, are almost invariably courteous and helpful, but conversation with the less well educated people can be difficult, owing to their peculiar accent and intonation, and their reluctance to admit that they have not understood you. Elementary education is free, but not compulsory, and there is still a good deal of illiteracy, especially in rural areas where schools are few and far between, and children are needed to work on the small holdings. The planters who own large tracts of land and the more prosperous inhabitants of the towns live in considerable luxury, but the standard of living of the peasants and of the unskilled workers in urban areas is deplorably low. In the country districts a typical family of five or more persons lives in a one-roomed wooden hut with a floor area of perhaps 12 ft. by 10 ft., having no kind of sanitation whatever. In the circumstances, it is perhaps not surprising to learn that a very high percentage of the births in Jamaica would be classified as "illegitimate" by English standards, though it is only fair to add that many of them are the result of what are called common law marriages, a voluntary association of the parents which generally lasts for a number of years and often throughout the period of child bearing.

There is no rationing in Jamaica and home-produced food is plentiful and good, but imported foods such as meat and bacon are scarce and dear. Bread is much whiter than in England, and there is no shortage of eggs or sugar. Yams, yampies and sweet potatoes are commonly used as a substitute for ordinary potatoes, which do not grow well in the island and are expensive. Tropical fruits of all kinds form the most attractive part of the diet. We at home are (or were) familiar enough with bananas and pineapples, and many of us have met mangoes in the form of chutney, but I imagine that few of us have ever heard of papaws, soursops, and many other fruits, the names of which I have already forgotten. In recent years Jamaica has suffered severe losses owing to the rapid spread of banana disease, which has made it necessary to destroy many square miles of valuable plantations. Experiments are being made with new varieties of banana, which it is hoped will prove more resistant to the disease, and attempts are being made to cultivate citrous fruits in the areas previously used for bananas. Jamaica is famous for its excellent rum, much of which is exported, but the local consumption must be heavy, as rum forms a characteristic feature of island hospitality. Wherever you call, and at whatever time of day, you are certain to be offered an iced drink containing rum mixed with lime, orange, ginger or plain water, according to taste. Although Jamaica is in the sterling area, it does not suffer from austerity as we do here. New English cars can be bought freely and without purchase tax, whilst petrol is obtainable in unlimited quantities at about 2*s.* 11*d.* a gallon. The shops in Kingston appeared to be full of English clothes (including nylon stockings), radiogramophones, chocolates of pre-war quality, and other luxury goods, and the chain-smoker can indulge himself at a fraction of what it costs him at home.

My three and a half weeks in Jamiaca passed all too quickly, and on July 12th I flew from Kingston Airport to Montreal on the first stage of my journey home. This flight, which was my first experience of air travel, took about 12 hours, including an hour on the ground at Nassau (Bahamas) and another hour at Toronto. I spent a day and two nights in Montreal, where I visited McGill University, and saw the Physics Department in which Rutherford, under whom I worked for so many years in Cambridge, first became famous for his pioneer researches in radioactivity. The final stage of my journey from Montreal to London Airport took about 16 hours, with stops at Gander (Newfound-

land) and Shannon. The airliners in which I travelled were air-conditioned and pressurised, and flew most of the way at a height of 15,000 to 17,000 ft. I found this mode of travel most comfortable, and much less tedious than I had anticipated, and I recommend it to anyone who has to undertake a long journey. Among my fellow-passengers were five with whom I had become acquainted during the outward voyage in the *Bayano*, and this added to the pleasure of the air trip. Three miles up the sunshine has a peculiar sparkle, the air a degree of clarity and the sky a delicacy of colouring not to be found at lower elevations, whilst the flat-topped cloud belt thousands of feet below looks like freshly fallen snow. I saw nothing of the Atlantic except a brief glimpse of the low shoreline of Newfoundland, and an equally fleeting impression of waves breaking on the rugged Irish cliffs as my plane emerged from the rainclouds and came down upon the wet tarmac at Shannon Airport in the grey dawn. Two hours later at Heath Row I found that a momentary break in the long spell of summer weather had produced leaden skies and a chill in the morning air, but when at length I reached my Surrey home after six weeks absence I felt no doubt that the quiet charm of the English countryside is a more satisfying thing to live with than all the exotic beauty of a tropical island, and that there is something to be said for the view that the best part of foreign travel is the return to England, even the England of 1949, with its rationing and controls, its crippling taxation, and its inability to earn enough dollars to maintain its standard of living.

Reviews

Biochemistry in relation to Medicine. By C. W. CARTER and R. H. S. THOMPSON. Longmans. *Price 25s.*

This book is a very fine piece of work. With Professor Thompson of Guy's as co-author, the scientific authority behind it is unassailable. What is more, it is no extensive treatise on biochemistry in all its ramifications but "discusses only those aspects . . . which are at present significant in medicine."

The question is for whom is such a text intended? The preclinical student searching for a lucid introduction to biochemistry up to the standard of 2nd M.B. may find it too ambitious, too controversial and even too up-to-date. The clinician, on the other hand, though he may enjoy reading it and appreciate at the same time the intricacies of a study that daily becomes even more important in practice, may fail to secure that guidance which he is ever seeking. There remains the physiologist himself, more especially the man doing the degree course. For him, no more valuable and progressive work is available and, what is more, the most comprehensive bibliography will prove invaluable.

This, then, is no examination aid but rather a survey of the latest advances and views on those sections of biochemistry with a medical import. If it fails always to explain it at least makes the reader think again.

G.

The Theory and Practice of Massage and Medical Gymnastics. By BEATRICE M. GOODALL COPESTAKE. 7th Edn. H. K. Lewis. *Price 21s.*

This book attempts to deal with too much substance in too small a space.

The chapters dealing with the theory and practice of Massage and Medical Gymnastics are clear and concise, if somewhat elementary.

The later chapters which deal with the application of physical methods to medical conditions are less happy. The pathology is often wrongly described or out of date, and too little information is given about the physical treatment. Though this book serves as an introduction to the subject, the syllabus of the Chartered Society has become so extensive that it is no longer adequate for the student preparing for her finals.

E.J.C.

Living Anatomy. By RONAN O'RAHILLY. Blackwell. *Price 5s.*

This is a small volume of notes on topographical anatomy, with references to physical, endoscopic, and radiological examination of patients. It is a correlation of information usually obtained from various sources, and may be useful to preclinical and clinical students, as a reminder of some of the anatomical landmarks used in clinical medicine.

P.L.

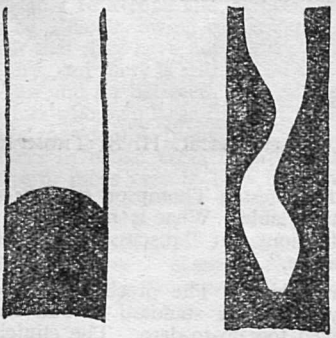
Lectures in Brief—VI.

PERIPHERAL VASCULAR DISEASE

By H. J. B. ATKINS, D.M., M.Ch., F.R.C.S.

ACUTE.

(*a*) *Embolism.* A peripheral embolus is seen most commonly in patients suffering from Mitral Stenosis, Aortic Disease or Atheroma. Should an acute ischæmic catastrophe occur in a limb when one of these conditions is present, the ætiological factor will itself point to the diagnosis. Although there is some difference of opinion about this matter, most people believe that pain is felt at the moment of impaction and at the site of lodgement, commonly the bifurcation of a main vessel. Later it is felt more distally where the avascularity is taking effect, and where no pulse is felt. Finally this same area may undergo a dry gangrene (more commonly when the clot is in the popliteal than in the femoral vessel). Arteriography will not only confirm the diagnosis, but will indicate accurately the level of the lesion.



(*b*) *Thrombosis.* This occurs in patients who are suffering from chronic arterial disease, especially atheroma. Whereas the clinical picture generally develops more slowly than in the previous group, and differentiation from embolus can be made on the history, it is occasionally relatively acute and, if it is due to atheroma which also causes embolism, distinction is not easy and entails arteriography. The obstruction in thrombosis is seen to be irregular in outline and proximally the affected vessel has a narrowed tortuous lumen. An embolus, however, shows up with a clearly defined convex surface. (See diagram.)

Treatment. In cases of embolism seen within about 8 hours, embolectomy should be undertaken. Patients seen later, and patients suffering from thrombosis, are best treated along general lines. The limb is nursed horizontally, the body kept warm while the extremity is kept cool, thereby increasing the blood supply and minimising the metabolic demands, and heparin is exhibited to prevent spread of the clot, which if it occurs, may jeopardise the collateral circulation. Sympathectomy also is employed in young patients to reduce the reflex spasm and thereby open up the collateral circulation.

CHRONIC.

Raynaud's Disease, Buerger's Disease and Arteriosclerosis (this term being used to include atheroma, medial sclerosis and Monckeberg's calcification) are the common causes of chronic peripheral vascular disease. They may be recognised histologically by their differing pathologies, but clinically an exact distinction, especially between Buerger's Disease and Arteriosclerosis, may not be possible.

(*a*) *Raynaud's Disease* occurs predominantly in women between their 30th and 50th years. The upper limb is most commonly affected and it is essentially a disease of the small digital vessels. The symptoms develop slowly and are most marked in the winter months when cold precipitates vascular spasm with marked pain and colour changes in the finger tips, which eventually become gangrenous. The distal pulse is undiminished in volume and on X-ray there is not uncommonly evidence of decalcification in the tips of the distal phalanges of the affected fingers. Advanced cases may display calcinosis, scleroderma or microstomia.

(*b*) *Buerger's Disease*, while affecting the same age group, is predominantly a disease of males, in whom the medium sized vessels, most commonly of the lower limb, are involved. Here the distal pulse is poor or absent and when the veins are involved as well, venous thrombosis may be super-added.

(*c*) *Arteriosclerosis* is a disease of 50 and onwards occurring most commonly in males, and involving the large and medium-sized vessels. Calcification in the main arteries may be felt on palpation and seen on X-ray.

Treatment. In Buerger's Disease and Arteriosclerosis the degree of vascular damage may be classified according to the symptomatology as follows :—

Stage 1.—Symptomless.

Stage 2.—Intermittent claudication. (Pain in the calf when walking, eased by rest).

Stage 3.—Rest pain. (Pain in bed, eased by hanging the leg out in the cool).

Stage 4.—Gangrene.

Raynaud's Disease, because it does not involve the muscular vessels, cannot be fitted into this classification. Here the treatment of the early case is conservative. Mittens must be worn in the house, and gloves when out of doors in the winter. Smoking must be cut down or cut out. The hæmoglobin must be raised to the optimal level. By these means, the advance of the disease can be delayed. Prestellate ganglionectomy produces initial improvement, and further delays the natural deterioration, but is seldom curative.

For cases of Buerger's Disease and Arteriosclerosis in Stage 1, there is no treatment. For cases in Stages 2 and 3, provided there is minimal calcification, sympathectomy is the treatment of choice. (In the rare cases shown by arteriography to be suffering from well localised disease, there may be a place for venous grafting). In Stage 4, conservative treatment should be employed in the first instance to allow sequestration to occur aseptically. Wet Eusol dressings are helpful. (It is not the wetness which makes moist gangrene lethal, but the sepsis). Amputation is indicated when the gangrene spreads and the pain is severe. In Buerger's Disease, sympathectomy may permit of a below knee amputation. In arteriosclerosis the amputation should always be through the thigh, and sympathectomy has no merit at this late stage.

H.A.R.

The Science Club

By H. St. H. VERTUE.

FOR the first meeting of the Science Club this season, Dr. Hughes was good enough to come down from the Strangeways Laboratory, Cambridge, to initiate a deeply interested audience into a world of wonder that only a few can have entered before. What he had to show us was nothing less than the active life of the cell grown in culture, living and propagating, as it is revealed by the two-phase microscope, with its structure displayed in detail, and, most striking sight of all, the vigour of its internal movements caught on a kinematographic film and projected on to a screen before our astonished eyes. This research, the achievement of a patient and devoted scientist, is intended primarily for the advancement of Science ; yet to men of penetrating mind the implications would surely be far-reaching. Tennyson would have been stirred by the spectacle, Shelley have gasped and Lucretius been profoundly moved. If my account is descriptive only, the reader must pardon me, for not the most gifted men in the assembly were inclined to offer explanations of what they saw in terms of current physiology.

The cell, which we are accustomed to see fixed and stained, is anything but immobile when alive. Within its boundaries, in constant agitation, are many granules, differing in size and refractivity. Their's is not a Brownian movement : it is far too vigorous and varied for that. What then is it ? No one knows ! Sometimes eel-like bodies appear, lash like a leech, writhe like a trodden worm and disappear again. These are the mitochondria. Then, the surface of the cell is never at rest. Bubbles arise and distend the envelope, which bulges before them, and anon they fall back and are gone ; but where there is water the cell behaves differently, throwing out a beautiful undulating membrane. As the gay motes that dance in the sunbeam, to and fro and up and down, testify to the unseen forces that propel them, so this marvel of movement in the living cell proclaims the presence of forces the nature of which is not yet known. The old words of the psalmist come back with fresh significance, " I am fearfully and wonderfully made."

All the while amid this heaving sea there has been an islet of calm, the nucleus—but not for long is it at rest. Fancy suggests that one is looking at a dimly lit hall, where workmen are sitting motionless, waiting for the order to begin. The command comes,

quite imperceptibly to us, and a turmoil of activity succeeds. The nucleolus disintegrates, dark forms scurry through a swirling fog, a spindle is descried and the dark forms are recognised as chromosomes. They meet together at the centre, facing each other in order like dancers. They have split in two, but too quickly for the eye to follow their doings. Then they retire in opposite ranks like partners in a quadrille, and as they part company the nuclear material goes away with them to the opposite ends of the cell. Next—the metaphore is irresistible—the cell is pinched in the middle by an unseen finger and thumb, the halves fly apart, drawn asunder by an invisible force, two now take the place of one, and the miracle of creation has been accomplished.

From those skiey towers
Where Thought's crowned powers
Sit watching your dance, ye happy Hours,
From the murmurings
Of the unsealed springs
When Science bedews her Daedal wings,

for a moment we were led away to get a glimpse of Hell's secrets. Mustard-gas had been applied to certain cells and the whole wonderful process of mitosis thrown into confusion. A use has been found for this notorious substance in arresting the excessive mitosis of leukæmia, but no mention was made of this fact at the meeting. The Science Club serves science not utility ; and here lies one good reason for attending its meetings.

In the drama that I have described the cells that took part were mostly the fibroblasts of the rabbit. The sound-waves conveying the name of the others were quaintly misinterpreted by my brain to represent the impossibility " toad's penis." No one could tell me what the words really were. The speed of the reel had been increased in transmission, but none of the implications were thereby diminished.

Will the path that the biologist is taking lead him at length to contemplations like those of the physicist ? The latter is as a man who has reached a cliff's edge and is gazing before him into an illimitable sea. The electron that he studies, for example, shoots through a mist like a meteor, but breaks through a gold plate like a wave through a harbour's narrow mouth. What, then, is an electron ? For our better comprehension it is pictured whirling round a nucleus like a planet round a sun, but at a speed beyond conception, which no one can believe in, jumping too, it may be, from one orbit to another in a way that seems impossible. Where, then, at any moment is this electron ? The æther, thought to be material when I was young, has been shewn now to have no material existence : yet the æther still exists, as Maxwell's equation. Again, when radiation is studied, the laws of mechanics no longer apply : there is probability but no certainty. Now the biologist, like the physicist, is spreading his scientific net of finest mesh to catch the tiniest creatures ; but he too may find when he has landed his haul, that there is still the unfathomable ocean. Science, in short, is no longer adolescent : it does not " explain " everything.

For us of the bedside, accustomed mostly to applied science, the breezes that flow from that ocean are healthful and invigorating. The Club is to be congratulated on the outstanding success of the first meeting of the season.

CONSTRUCTIVE ACHIEVEMENT

Members of the Hospital accustomed to using the back entrances (especially by the Talbot) will have noticed the huge steel chimney which is arising from the Works Department yard. Spurning the chaos of pipes, bricks, drains and holes at its foot this new creation has now reached a height of about 150 feet. This is 20 feet higher than the old concrete smoke-stack. Before use it will have to be lined with fine brick, but even then it will be some months before the furnaces to it are completed and a further contribution is made to the Boro' atmosphere—this time, with less solid matter, no doubt.

Correspondence

The Clubs' Union

SIR,—May I use your columns to give a brief account of the financial affairs of the Clubs' Union, on which subject a number of members is probably not well informed?

The income of this body is derived principally from students' subscriptions and a grant from the Medical and Dental Schools. Out of this sum certain recurring expenses must be met, such as rent for the sports ground at Honor Oak Park, maintenance of this ground, the pavilion, spectators' stand, machinery and salaries of ground staff. The catalogue could be continued indefinitely.

This does not include any provision that has to be made for extraordinary expenditure. From time to time it is necessary to spend a large sum of money, usually running into four figures, on some capital expenditure. At the present moment repairs are urgently needed to the pavilion, the stand, the gates and fencing, tennis courts, etc.

The remainder is set aside for the use of the constituent institutions, and the Clubs' Union Council endeavours at the October meeting to distribute this sum as equitably as possible among these clubs according to their needs as set down in the Club Budgets.

It is important that members recognise that their entire subscription of £5 5s. per annum cannot return to them in terms of sport and travel, because of the recurring expenditure already mentioned. The considerable amenities offered by the Students' Club must also be borne in mind.

During the seasons 1947–48 and 1948–49 the Clubs' Union incurred a loss, the amount involved being a not inconsiderable sum of money.

I hope this note will serve to remind members of some of the less obvious activities of this organisation, without which there could be no facilities, and also of the fact that the annual subscription, though now compulsory, stands at its pre-war level of five guineas. The Council is very anxious to avoid any increase in the subscription, and hopes that all members will appreciate the necessity for economising at this stage in view of the rising expenses of the Clubs' Union.

Yours, etc.,

P. G. LARGE,
Honorary Secretary, Clubs' Union.

Medical School,
Guy's Hospital, S.E.1.

Information

SIR,—I ask the hospitality of your correspondence columns for a plea for information from the Board of Governors of the Hospital.

During the last few days excavation work has started on the island of grass in the Park by the Memorial Gates. Apparently the site is being prepared for a kiosk for *W. H. Smith & Son, Ltd.* Could we not have some official statement about the reasons for and the scope of this scheme?

I voice the opinions of many in asking for information on the following points :—

1. Granted that the newspaper and magazine service for patients is inadequate, is this the best way of meeting the need? Is a large, prominently-placed kiosk necessary? Has thought been given to other solutions of the problem?

2. Since the Park is a unique feature of Guy's, has full consideration been given to the effects of this encroachment on the amenities, and have guarantees been obtained that the building will not be an eye-sore?

3. Is this to be regarded as a precedent? What will be the Governors' response to pleas for a barber's shop and a beauty salon?

4. What steps have been taken to limit the scope of merchandise for sale? Will this outside firm compete with the Hospital-sponsored Guy's Shop? Since *Smith's* and other firms will want to enter other hospitals in a similar manner, has the Ministry of Health approved this unusual principle, that outside concerns should be allowed to operate inside state organisations?

Undoubtedly the Board of Governors, in the full study that must have been made of such a new scheme, has given adequate consideration of all these points, and has satisfactorily resolved the problems in its own mind; however, I would make a plea for greater information to the student body on such issues.

I realise that students are the responsibility of the Medical School Council and not of the Board of Governors, but it is mainly the Hospital that provides us in our after-years with the memories and maintains the affection and respect that Guy's men feel.

A lesson of general application can be drawn from this matter. Could not the Board of Governors, directly or through the Superintendent, take steps to inform students of the reasons for such new measures? (A letter to the *Gazette* is as effective way as any—*vide* the one on tree-felling in the Park.) In this simple way much of the unhappy bewilderment that results from lack of information could be prevented.

Yours, etc.,

LEONARD JACOBS.

29, St. John's Wood Terrace, N.W.8.

Guilty But Insane

SIR,—Correspondence from New Zealand must of necessity arrive after so great a delay that the *Gazette* article to which it refers may, in some cases, have ceased to be a matter for topical discussion. Surely this cannot be the case with Keith Simpson's lecture, " Guilty but Insane," which I feel sure will be referred to and quoted by all who have the good fortune to read it, especially those whose work puts them in the way of Courts.

I was particularly struck with the healthy avoidance of technicality and would like if space permits to give just one further illustration to the last paragraph.

I quote from the Clarke case in which I was concerned for the defence. In 1940 Pte. Clarke was tried for the murder of a fellow machine gunner in the New Zealand Expeditionary Force, then stationed in Kent. A defence of insanity was put up and at the first trial the jury disagreed (their disagreement being perhaps not unconcerned with the lateness of the hour and the imminence of the air-raid warning).

At the second trial a point was made as to the physical characteristics of the accused, whose height was given as 5 ft. 4 in. Counsel for the defence queried that height and the judge directed that the accused should be again measured in prison and an amended measurement of 5 ft. 3⅝ in. was given in court the following day. Clarke was found guilty but insane and committed to Broadmoor.

Some five weeks later I by chance met a member of the jury who explained how the jury had arrived at its verdict. Having listened to the medical evidence of the prison doctor and the psychiatrists for the defence (Dr. Noel-Harris and myself) they came to the conclusion that if the prison doctor was unable to correctly measure the accused's height, surely he would be incapable of measuring the state of his mind.

G. BLAKE-PALMER.

Mental Hospital,
Auckland W3,
New Zealand.

SIR,—Dr. Gavin Thurston's zeal in disputation has involved him in a certain amount of special pleading. The jury are required to arrive at a verdict, which may be either guilty, not guilty, or guilty but insane. The latter verdict presumably involves a decision about the prisoner's sanity. The fact that this decision has to be based upon criteria exclusively concerned with the validity of delusions as a basis for action, is precisely the ground on which these rules are criticised. He goes on to defend them on two counts: one, that they are " far from an arbitrary formulation, being the considered opinion of Her Majesty's judges "; the other, that they are part of the jury system " which has stood the test of centuries."

With regard to the first point, even if we presume that Her Majesty's judges were fully abreast of current medical views in 1843, when they delivered themselves of their opinion, we ought still, perhaps, to admit that knowledge of mental and emotional processes, like every other branch of medicine, has progressed a little in the past 106 years, and the change deserves recognition. The second point implies the assumption that the McNaghten rules are in some way indispensable to the jury system. In this connection it is of interest that in the Commonwealth of Massachusetts the procedure actually adopted is very similar to that advocated by Doctors Gillespie and Henderson and outlined in my letter, but the jury remain the sole deciders of fact in respect to the charge with which the prisoner is accused, and are of course responsible for the verdict of guilty or not guilty.

Yours, etc.,

D. STAFFORD-CLARK.

Massachusetts General Hospital,
Boston, 14.

Sport

RUGBY FOOTBALL

Guy's *v.* Plymouth Albion

At Plymouth. Lost 3—9.
22nd October, 1949.

Guy's began their short tour by playing Plymouth Albion. The conditions were bad, the ground was wet and heavy, and a strong wind blew for most of the game. When this dropped it rained heavily. The ball was wet and difficult to handle. In spite of this, much of the play was open.

The forwards obtained a major share in the tight scrums and held their own in the loose. Many attacking movements were seen but owing to a sound defence on both sides nothing resulted.

Plymouth took the lead with an unconverted try, but Guy's equalised before half-time when Keen cut through in the centre and threw out a long pass to Middle who scored in the corner.

The main feature of the second half was the fine performance of D. le Clus at full-back who constantly found touch with long kicks. Plymouth pressed hard and Guy's did well to prevent a score for a long time. Finally a quick heal from the loose caught the Guy's defence on the wrong foot, and Plymouth scored another try.

Guy's fought back and came near to scoring on several occasions, but in the end Plymouth increased their lead by another try.

Guy's *v.* Paignton

At Paignton. Lost 0—3.
24th October, 1949.

This game saw Guy's in their most attacking form so far this season. A grand open game with many thrilling movements ended in Paignton winning by a try to nothing.

In the tight the Guy's forwards did well once again but were sluggish in the loose and the Paignton forwards came through frequently. At half-time there was no score.

In the second half Guy's nearly scored on two occasions when F. le Clus made gaps in the centre and sent G. Baker away. The movements lacked finish but this will come with experience. The impression gained from the game was that the Guy's team may develop into a strong, balanced side. F. le Clus at stand-off played outstandingly well and there was thrust in the centre.

Guy's *v.* Old Alleynians

At Dulwich. Lost 5—8.
29th October, 1949.

In this game W. S. Howells was brought into the centre and made an extremely promising start. The Old Boys' forwards played a fast game and outplayed the Guy's pack. The difference was particularly marked in the loose where the quick healing of the Old Boys rapidly had the Guy's team on the defensive.

Quite against the run of the play, Guy's took the lead when Howells picked up a loose ball in the centre and gave Birch a clear run in. Davies converted the try. At this point G. Bellis was knocked out and had to be carried off. The Old Alleynians scored a try due to a defensive lapse on the part of the back row.

Playing down hill in the second half it seemed that Guy's would win. Their forwards were bustled so effectively, however, that they were unable to heal the ball quickly and cleanly. Several times a score seemed imminent but was missed at the last minute.

Bellis came back at this stage and Guy's pressed hard. However, shortly before the end the Old Boys went ahead when one of their number ran through the Guy's team to score. The kick was successful.

Guy's tried desperately hard in the remaining minutes but without result, and so were beaten. The game underlined the importance of winning the ball in the forwards and the pack did not look fit enough.

By kind permission of "The Paignton News."

AN ACTION PHOTOGRAPH TAKEN DURING THE DEVON TOUR

ASSOCIATION FOOTBALL

SOUTHERN AMATEUR LEAGUE

Guy's *v.* Bank of England

At H.O.P. Lost 0—1.
5th November, 1949.

The pitch, very wet on the surface, made control of the ball extremely difficult, a phase of the game which Guy's did not master, and hence suffered their first defeat of the season.

Generally the Bank team appeared faster on the ball and into the tackles than Guy's, the result being a complete domination of the centre of the field by the Bank of England side in their own half. The defences ruled the day, a fact proved when it is realised that the number of shots the goalkeepers were called upon to save were well below double figures. Allen and Mathews were prominent in the Guy's defence.

The Bank's goal came early in the first half, and although Guy's held them to this one goal lead, they could not make good the deficit.

Territorially Guy's were the better side and many promising and good forward moves finished with a weak or ill-directed shot, which no more than proved rather than tested the opposing goalkeeper's efficiency.

Guy's team : A. Fearn ; D. M. Lipington, M. Bishop ; D. Mathews, D. Allen, A. Swift ; B. Cornhill, C. Leckie, D. Harris, A. Prince, E. Sturdy.

Guy's 2nd XI. *v.* Bank of England 2nd XI.

Away. Lost 1—4.
5th November, 1949.

HOCKEY

Guy's *v.* Inland Revenue

Away. Won 1—0.
5th November, 1949:

Guy's *v.* Gravesend

At Gravesend. Won 4—1.
12th November, 1949.

Another day of stormy hockey with rain, hail and gales attending the first half. Guy's, with the advantage of playing with the gale, opened the scoring with a shot from Meyer. When the rain stopped Guy's, by adapting themselves to the state of the pitch, held the advantage throughout the game. Blake put Guy's two ahead, but before the interval Gravesend's centre-forward broke through to score their only goal. Guy's defence held Gravesend's attack and Opie scored two goals to put Guy's three ahead, a result which somewhat belied the keenness of the game.

Team : F. H. Walker ; G. H. Danford, H. Carter ; C. Robinson, E. A. Murray (Capt.), W. Dobson-Smyth ; D. V. Duckworth, D. E. Blake, H. Meyer, C. H. Opie, A. Blower.

Other results—

Guy's II *v.* Gravesend II. Draw 1—1.

Guy's III *v.* Gravesend III. Lost 0—3.

Guy's Diary.

ACADEMIC

November

Exhibition. Surgical Department. "Obstructive Jaundice."
21st. 3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
22nd. 1.00. Dr. Evans. Clinical Lecture. "Rheumatic Fever in Childhood."
24th. 1.00. Mr. Lawrie. Clinical Lecture. "Internal Derangement of the Knee."
4.30. X-ray Demonstration. Gordon Museum.
25th. 2.15. Medical Department. Combined Round. Preclinical Classroom.
26th. 10.00. Surgical Department. Clinico-Pathological Meeting. Anatomy Theatre.
28th. 12.00. Mr. A. R. F. Thompson. Dental Clinical Lecture. "Apicectomy." Dental Theatre.
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Department of Child Health. Film Show. "Mechanism of the Brain."—Pavlov. Anatomy Theatre.
29th. 12.00. Medical Department. Neurological Demonstration. Preclinical Classroom.
1.00. Dr. Bishop. Clinical Lecture. "Diseases of Adaptation."

December

Exhibition. Surgical Department. "The Maintenance of Nutrition."
1st. 1.00. Mr. Massie. Clinical Lecture.
4.30. X-ray Demonstration. Gordon Museum.
2nd. 1.00. Dr. Boland. Clinical Lecture.
2.15. Medical Department. Combined Round. Preclinical Classroom.
5th. 1.00. Dr. Rink. Clinical Lecture. "Uses and Abuses of Pentothal."
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

OTHER ENGAGEMENTS

November

21st. Rugby XV. *v.* University College, Dublin. (H.O.P.).
26th. Rugby XV. *v.* Old Whitgiftians. (South Croydon).
Association Football 1st XI. *v.* Police College, Hendon. (Away).
Hockey 1st XI. *v.* Lensbury. (H.O.P.).
Hockey 2nd XI. *v.* Lensbury. (Away).
Hockey 3rd XI. *v.* Lensbury. (Away).
28th. Association Football 1st XI. *v.* Birmingham University. (H.O.P.).
29th. 5.00. Dental Society. Film. "Dental Hygienists in New Zealand." Dental Lecture Theatre.
30th. Association Football 1st XI. *v.* Normandy Company. (Away).

December

3rd. Rugby XV. *v.* Coventry. (H.O.P.).
Association Football 1st XI. *v.* Northampton E.C. or Royal Vets. (H.O.P.).
Association Football 2nd XI. *v.* Old Westminster Citizens. (Away).
Hockey 1st XI. *v.* Sittingbourne. (Away).
Hockey 2nd XI. *v.* Hay's Wharf. (H.O.P.).
Hockey 3rd XI. *v.* Oxted. (Away).

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL

Applications are invited for the post of **Senior Registrar** in the **Radiotherapy Department.** It is desirable that candidates should hold a Higher Qualification in Surgery or Medicine, or a Diploma in Radiotherapy. Salary in accordance with Terms and Conditions of Service of Hospital Medical Staffs, *i.e.* £1,000 per annum. Application forms are obtainable from the Dean, Guy's Hospital Medical School, London Bridge, S.E.1, and should be forwarded with the names of three referees not later than 29th November, 1949.

Applications are invited for the appointment of **Registrar, 1st year,** to the **Evelina Hospital** for Sick Children, Southwark Bridge Road, S.E.1. Commencing date early in the New Year, 1950. Forms of application are obtainable from the Dean, Guy's Hospital Medical School, and should be forwarded to him not later than 22nd November, together with the names of three referees.

CHRISTMAS CARDS

Views of the Hospital on Christmas Cards may be obtained from the *Gazette* Office, 6 St. Thomas Street, S.E.1. Prices 5/- and 3/- per dozen including envelopes (per post 6d. extra).

ROYAL COLLEGE OF SURGEONS OF ENGLAND

At a quarterly meeting of the Council of the College held on October 13th it was reported that Professor R. V. Bradlaw would deliver the first Webb-Johnson Lecture.

PASS LIST

ROYAL COLLEGE OF PHYSICIANS OF LONDON

M.R.C.P.

S. L. O. Jackson
M. H. Lessof
J. K. Morgan
N. A. Neville
M. G. Thorne
G. F. Vaughan
J. Wedgwood

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.D.S.

S. W. Charles
W. F. Collyer
G. W. Gathergood
K. P. Liddelow
A. R. Thompson

ROYAL COLLEGE OF SURGEONS OF ENGLAND

FINAL EXAMINATION.

L.D.S.

October, 1949.

Part I.—Surgery.

G. V. Crine
W. F. Dobson
P. Frank
W. J. George
H. E. H. Gillett
P. J. Holloway
J. H. Lee
A. A. Leigh
W. H. Legg
H. Levison
R. R. Lewis
R. Marx
R. Skaith
P. A. Swift
J. L. Wynne

Part II.—Dental Surgery.

E. J. Beaton
A. Black
B. M. Gray
D. M. Griffith
P. Griffiths
P. F. Howe
J. H. Lee.
G. E. Moore
M. P. O'Reilly
H. L. Scott
M. J. Smallcombe
P. J. Wright

PASS LIST

CONJOINT BOARD

D.T.M. and H.

P. H. Birks

D.C.H.

K. E. Jefferson L. Hass. A. F. H. Stewart

FINAL EXAMINATION.

October, 1949.

Pathology.

H. M. Baird
R. Baxter
A. E. R. Buckle
J. C. Camac
D. F. C. Deacon
A. C. de B. Eksteen
J. R. Evans
N. S. Galbraith
G. A. L. G. Glazebrook
T. S. Hart
J. M. Holden
J. W. Hughes
G. A. Lawrence
M. Lewis
M. J. R. Mackrill
I. J. MacQueen
R. C. Michell
R. C. Nauth-Misir
*D. F. Potter
R. J. Powell
A. M. Reader
K. F. Robinson
I. Rocker
P. R. Sowerby
D. E. Sturdy
M. G. Thompson
R. A. J. Williams

Medicine.

*B. L. Bisley
D. L. Blundstone
*G. Canty
J. D. Crowlesmith
A. R. Davis
*A. K. Doust
*R. H. P. Fitzpatrick
J. Foley
*J. B. Gayes
*H. R. E. Gillespie
R. Goulding
*T. C. Hopkin-Husson
*L. W. Mackey
M. Mason
D. S. Noble
G. F. M. Pierce
*D. F. Potter
L. Tann
W. N. Whamond
*B. L. Whitaker

Surgery.

*A. K. Doust
*R. H. P. Fitzpatrick
*J. B. Gayes
*D. M. Lewis
K. G. P. Mackenzie
*L. W. Mackey
*A. M. Platt

Midwifery.

B. I. Copeland
J. D. Crowlesmith
G. R. C. Deacon
J. F. A. Everson
H. G. Hexter
H. N. St. John
S. F. Knipe
D. Lennie
M. Mason
P. A. Van der Merve
J. H. Ratcliffe
F. B. Sartory
L. Tann
C. B. Vaughan
R. I. J. Williams
I. J. P. Woodhouse

* Have completed the examination.

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

October, 1949.

Surgery.

*A. K. Doust
*E. T. King
*S. S. Maré

Pathology, Bacteriology and Forensic Medicine.

A. C. de B. Eksteen
S. A. Jolliffe
E. C. Lewis

Medicine.

S. A. Jolliffe
*E. T. King

Midwifery.

H. G. Hexter
P. A. Van der Merwe
J. S. G. P. Stapleford

* Have completed the examination.

ROYAL COLLEGE OF PHYSICIANS OF LONDON

Dr. Maurice Shaw has been elected additional examiner for the Membership examination.

PAPERS BY GUY'S MEN

Bishop, P. M. F. Hormone Implantation Therapy. *Practioner*, 1949, **163**, 437.

Blackburn, Guy. Mediastinal Tumour. *Med. Soc. Trans.*, 1947–9, **65**, 478.

Cappon, D. Suicide and the Law. *Nursing Times*, 1949, **45**, 898.

Chick, A. O. The forward of the mandible during bite closure and its relation to Excessive Alveolar Resorption in Edentulous Cases. *Brit. Dent. J.*, 1949, **87**, 243.

Covell, Sir Gordon, and Others. The Pre-erythrocytic stage of plasmodium falciparum. *Brit. Med. J.*, 1949, ii, 1006.

Douthwaite, A. H., and Another. Treatment of Peptic Ulcer. *Med. Soc. Trans.*, 1947–9, **65**, 281.

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Hinde, R. T., and Another. Two Cases of lateral Sinus Thrombosis. *J. Laryngol. Otol.*, 1949, **63**, 605.

Hunt, J. N. Choice of a Test-meal. *Lancet*, 1949, ii, 794.

Jacoby, N. M., and Taylor, A. W. Acute Polyarteritis Nodosa in Childhood. *Lancet*, 1949, ii, 792.

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MacKeith, Ronald. Infant Feeding Today. Part I.—Breast-feeding. *Med. World*, 1949, **71**, 385.

Marshall, Geoffrey. The Surgical Treatment of Pulmonary Tuberculosis. *Med. Soc. Trans.*, 1947–9, **65**, 128.

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Ogilvie, Sir Heneage. In praise of Work. *Brit. Med. Students J.*, 1949, **4**, 9.

Oliver, Leslie C. The Treatment of Brain Abscess. With special reference to a Conservative Method. *Lancet*, 1949, ii, 828.

Rake, G., and Others. Investigations on the Streptomycins. *J. Clin. Invest.*, 1949, **28**, 846.

Robin, Ian G. Large Mixed Salivary Tumour in the Hard Palate. *Med. Soc. Trans.*, 1947–9, **65**, 279.

Ryle, J. A. Teaching and Research in Social Medicine. *Med. Soc. Trans.*, 1947–9, **65**, 335.

Symonds, Sir Charles. Symptomatology and Treatment of Displaced Intravertebral Discs. *Med. Soc. Trans.*, 1947–9, **65**, 23.

Tanner, W. E. Large Cystic Fibro-Adenoma of Breast. *Med. Soc. Trans.*, 1947–9, **65**, 280.

——. More Worthies in Medley's Picture of the Founders of the Medical Society of London. *Med. Soc. Trans.*, 1947–9, **65**, 348.

——. The Guy's Worthies in the Early Years of the Medical Society of London. *Med. Soc. Trans.*, 1947–9, **65**, 226.

APPOINTMENTS

H. L. Brunow, F.R.C.S., appointed Surgical Registrar, Lewisham General Hospital.

BRITISH ASSOCIATION OF DERMATOLOGY AND SYPHILOLOGY INTERNATIONAL CONGRESS 1952

Dr. G. B. Dowling has been appointed to the Sub-Committee set up to study preliminary arrangements.

AWARD OF BLUES

At its meeting on October 14th, the Clubs' Union Council approved the following recommendation of the Blues Committee :—

	Blues.	*Half-Blues.*
Athletics Club		M. K. Strelling A. A. Roe
Boat Club	J. D. Hooper J. Hunt E. P. W. Tatford	D. C. A. Pickton R. C. C. Thompson R. C. Francis
Boxing Club	N. H. St. John	N. P. O'Reilly D. Lipington E. E. Ecksteen R. C. C. Thompson N. Halamandres D. M. Griffiths
Fencing Club	J. H. Wilson J. A. W. Scott	H. W. Rowell
Hockey Club	D. E. Blake S. R. Earle L. Mackey C. H. Opie	D. V. Duckworth R. F. Hodson C. F. M. Robinson
Ice Hockey Club	P. F. Howe H. Aldwick	J. Aust
Rifle Club	C. P. B. Brook	J. W. Comper
Rugby Club	A. N. Du Plessis N. Malyon P. Rademan A. A. Bailey K. Heber	G. W. Davies E. S. P. Williams J. Hobbs J. Kirkbride J. Robinson J. Payne P. S. B. Russell T. Smith
Association Football Club		D. M. Lipington J. F. H. Young A. d'A. Fearn V. G. Rice
Squash	D. P. Pugh	P. L. Pickett D. E. Blake

P. S. B. RUSSELL,
Hon. Sec. Blues' Committee.

CHANGES OF ADDRESS

C. Z. Joiner, M.B., M.R.C.P., 40, The Chase, Clapham Common, S.W.4. (Tel. Macaulay 5420.)

J. K. Morgan, M.B., M.R.C.P., 1, Victoria Avenue, Sunderland, Co. Durham.

G. F. Swann, M.B., B.S., Belcher's Farm, Nazeing Essex. (Tel. Nazeing 2188.)

BIRTHS

WALLACE.—On November 8th, 1949, at Grantham Hospital, to Ruth (née Hersant), wife of Dr. Kenneth Wallace—a son (Mark Alastair).

DEATHS

BOLLARD.—On October 28th, 1949, Willie Julian Bollard, L.D.S. R.C.S. Eng. 1904, of Homefield, Babbacombe, Devon.

EDS. {R.G. P.A.Z.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry, and Hospital News

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PASSIM

ANY profession which makes big demands upon a man's time tends to narrow his outlook. Any professional man who wishes to become great rather than brilliant at his work will resist this tendency. This applies to the qualified professional man and to the Student equally. The subject has been dealt with in these columns on more than one occasion. We make no apology for raising it again. At the present time, Guy's Students receive training probably as good as that of Medical and Dental Students anywhere in the world. Whether their general education, the term is used in its widest sense, is of the same quality we are not so sure. We believe it could be bettered. Furthermore we believe it could be bettered to a considerable extent by no more complex a measure than that of making fewer demands upon their time. Throughout the Hospital, through all the years, we find students overburdened with work. Much of this work is essential to their training, but by no means all. It is our contention that there are subjects taught in unnecessary detail and studied in unnecessary detail and this detail may obscure the general principle lying beneath it. We plead, therefore, in the interests of the wider education of future generations of medical students, for the ruthless pruning of unnecessary teaching and for less encroachment upon a student's spare time.

It is not our purpose to plead for time so that students may fritter it worthlessly away, but so that they may have time to do more unorganised work within the Hospital, to think more about the work which they are already doing, to play more games, to move more widely outside the Hospital, to lay those foundations of outside interests, and to acquire some social attributes, all of which in later years will be one of the surest guarantees that they are educated gentlemen as well as competent technicians.

You will wonder, no doubt, whether we have any positive suggestions to offer, ndeed we have. On another page the Captain of Rugby asks for the slight rearrangement of work to enable Wednesday afternoon to be completely free for sport. His request has our fullest support. We suggest, in addition, that there are subjects in the first and second M.B. and Clinical Courses which need be taught in less detail, notably Botany, Chemistry and Anatomy in the early years, whilst in the Clinical years Clerks are, we believe, bothered with details of numerous investigations, electrocardigrams, and the like ; investigation which may possibly be of importance to them, when they have mastered the far more important business of taking case histories and eliciting physical signs, but certainly not sooner.

These are suggestions. There may be others and better ones. We feel the matter is worth the notice of those concerned. The curious feature of the situation, however, is that students at the present time appear to be working harder than is required of them by their tutors. We get the impression, therefore, that it is a slavish adherence to programme by the student rather than hard driving by their tutors which lie at the root of the trouble. Whatever the truth of this, we feel that, if the set programme were to be modified and the student given more unorganised time during the day a step forward might be taken towards his wider education. It is, after all, the best balanced and most widely educated student who is most likely to make the best General Practitioner.

Facial Paralysis

By PHILLIP READING, M.S., F.R.C.S.

Being the abstract of a Clinical Lecture delivered at Guy's Hospital on 5th September, 1949.

IN its passage from the brain to the periphery, the facial nerve pursues a course which brings it into close contact with the internal and middle ears. Injuries and diseases of the ear often implicate the nerve, and the otologist has an excellent opportunity of studying the effects in clinical practice.

Accompanied by the nervus intermedius, the facial nerve emerges from the brain at the lower border of the pons and crosses the subarachnoid space to enter the internal auditory meatus along with the eighth nerve. It passes over the top of the internal ear, and runs outwards between the superior semi-circular canal behind and the cochlea in front. This path conducts it to the medial wall of the middle ear, whereupon it makes a right angled turn (the knee or geniculum) and runs horizontally backwards, the oval window lying below and the horizontal semi-circular canal above its course. At the knee the nerve is swollen by the presence of the geniculate ganglion. Having passed along the medial wall of the tympanum, the nerve makes another turn and bends downwards. It passes through a bony tunnel posterior to the back wall of the tympanum, and emerges through the stylo-mastoid foramen. Winding round the styloid process, it pierces the substance of the parotid gland and breaks up into a leash of fibres.

The facial nerve subserves at least three, and possibly four functions. It is a motor nerve, supplying the muscles of the face, the stapedius, the posterior belly of the digastric and the stylo-hyoid muscles. It is the nerve of taste to the anterior two-thirds of the tongue, it conveys secreto-motor fibres to certain glands, and it may possibly transmit deep painful stimuli.

Let us consider first its motor functions. It supplies a small twig to the stapedius muscle. Injury of the main trunk, proximal to the point where this branch is given off, leads not only to facial paralysis, but also to slight deafness and tinnitus. No clinical significance attaches to the branches supplied to the posterior belly of the digastric and to the stylohyoid muscle.

In the face, the fibres are divisible into an upper and a lower bundle. The upper supplies the orbicularis oculi, and the frontalis muscles. Paralysis of these muscles leads to inability to shut the eye and to wrinkle the forehead. Any attempt to shut the paralysed eye causes an unsightly rolling up of the eyeball, so that the white of the eye is exposed between the open lids (Bell's Sign). The lower bundle innervates those muscles which control the corner of the mouth, the orbicularis oris and the buccinator. If these muscles are powerless, food collects in the pouch of the cheek, and fluids dribble over the paralysed lower lip. Facial palsy not only inflicts a deformity, but also interferes considerably with mastication. The cervical branch sinks to the level of the hyoid bone to supply the platysma and is liable to accidental division in surgical incisions over the sub-maxillary triangle. This accident is followed by a trivial, but distressing weakness of the corner of the lower lip.

Movements of the facial musculature are controlled by an upper and a lower motor neurone. The former comprises nerve cells in the lower part of the pre-Rolandic gyrus and their efferent fibres which cross the middle line and ramify round the facial nucleus in the pons. Some of the fibres devoted to the regulation of the frontalis muscle do not decussate, but descend uncrossed to the facial nucleus of the same side, some decussate and reach the heterolateral facial nucleus. Lesions involving the upper motor neurone, therefore, give a hetero-lateral facial palsy, involving all the facial muscles except the frontalis muscle, which derives its nerve supply partly from the unaffected homo-lateral cortex. The patient is still able to wrinkle his forehead on the paralysed side, a valuable clue in the localisation of the lesion.

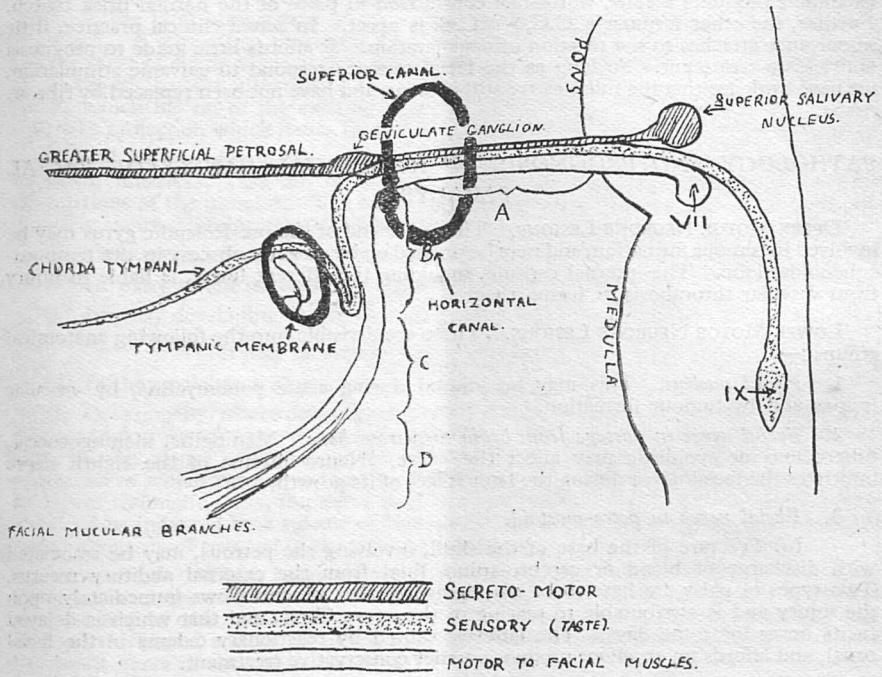
The lower motor neurone consists of the facial nucleus and of its efferent fibres in the facial nerve. Any disaster overtaking the nucleus or the main nerve trunk is reflected in a total paralysis of the same side of the face.

Before discussing further the symptomatology of facial paralysis, we must return to a consideration of the other functions of the nerve, and indicate their nature and the paths which they follow.

The nerve of taste to the anterior two-thirds of the tongue arises from the upper end of the glosso-pharyngeal nucleus in the medulla. Its fibres ascend the brain stem and emerge in the nervus intermedius. This, the sensory root of the facial nerve, has its cell station in the genicular ganglion, which has been regarded as analagous to the sensory ganglia of the spinal nerves. The sensory fibres leave the main trunk of the facial nerve at the point where it is coursing downwards behind the tympanum. They pass across the middle ear, as the chorda tympani, closely applied to the medial surface of the tympanic membrane, and join the lingual nerve. With the branches of the latter, they are distributed over the front of the tongue. The posterior third of the tongue is supplied by other fibres from the glosso-pharyngeal nucleus, which run in the substance of the glosso-pharyngeal nerve.

The seventh nerve supplies secreto-motor fibres to the lacrimal, pharyngeal and nasal glands. The centre in the brain is the superior salivary nucleus. Thence the fibres run in the substance of the nervus intermedius to the genicular ganglion, and emerge on the superior surface of the petrous bone as the greater superficial petrosal nerve. This is joined by fibres from the pericarotid sympathetic plexus (deep petrosal nerve) and, as the Vidian nerve, it reaches the spheno-palatine ganglion. Fibres are dispatched from this to the mucous glands of the nose and pharynx and also to the lacrimal gland. The secretion of tears is easily tested at the bed-side. Unilateral absence of tear secretion, on stimulation of the olfactory tract by irritating vapours, is a strong indication of a lesion of the greater superficial petrosal nerve.

The points of departure of these various branches from the main trunk of the facial nerve provide us with milestones by which we can judge the extent of a lesion of the nerve.



The passage of the facial nerve from the brain, across the subarachnoid space and over the top of the internal ear is comprised in the bracket A. Injury to this part of its course will cause all the functions of the facial nerve to be suspended, together with evidence of involvement of the inner ear or the eighth nerve (deafness, vertigo). Injury in the area marked B, *i.e.* in the tympanic course of the facial nerve, brings about a complete unilateral facial palsy and a loss of taste of the front of the tongue on the affected side. The inner ear may or may not be involved, and the greater superficial petrosal nerve will escape. Injury at C, below the point of departure of the chorda tympani, causes only a muscular paralysis, all the other functions escape damage. Lesion at D, where

the nerve is splitting into numerous filaments to supply the facial muscles, will entail paralysis of some of these muscles only.

Such a nice division of the nerve into layers of differing function is an entertaining arm-chair exercise, but unfortunately it does not always prove of great diagnostic value. Any lesion of the nerve, traumatic or inflammatory, causes considerable œdema, which filters up the bony tunnel encasing the nerve. Parts of the nerve at some distance from the original lesion may be pressed on and paralysed. The resulting neurological picture may mislead the observer.

REACTION OF DEGENERATION.

The normal reactions of a healthy nerve and muscle on electrical stimulation are these :—

Feradic stimulation causes a brisker contraction than galvanic. This may be expressed F > G.

On galvanic stimulation, there is a stronger twitch of the muscle on closure of the kathode key than on closure of the anode key. Kathode closure contraction (K.C.C.) is greater than anode closure contraction (A.C.C.) and both are greater than the contractions obtained on opening the circuit. Thus K.C.C > A.C.C.

No change occurs in the electrical excitability of the muscle till some ten days after injury to its nerve. Then the reaction of degeneration is apparent. The response to faradic stimulation decreases so that the formula F > G is reversed, and galvanic excitation produces a slow, worm-like contraction in place of the normal brisk twitch. Further, the other formula K.C.C. > A.C.C. is upset. In actual clinical practice, little importance attaches to the reaction of degeneration. It affords little guide to prognosis and less to treatment. So long as the facial muscles respond to galvanic stimulation, we have evidence that the muscles are still present, and have not been replaced by fibrous tissue.

PATHOLOGY AND PROGNOSIS OF INDIVIDUAL CAUSES OF FACIAL PARALYSIS.

Upper Motor Neurone Lesions. The lower end of the pre-Rolandic gyrus may be involved in tumour formation, and may be pressed on by otogenic abscess in the temporo-sphenoidal lobe. The internal capsule, including the efferent fibres, is liable to injury from vascular thrombosis or hæmorrhage.

Lower Motor Neurone Lesions. These are divisible into the following anatomical groups :—

1. *Facial nucleus.* This may be injured during acute poliomyelitis, by vascular lesions and by tumour formation.

2. *Facial nerve in passage from brain to petrous bone.* Meningitis, meningococcal, tuberculous or syphilitic may affect the nerve. Neuro-fibroma of the eighth nerve infiltrates the facial nerve during the later stages of its growth.

3. *Facial nerve in petro-mastoid.*

(*a*) Fracture of the base of the skull, involving the petrous, may be associated with discharge of blood or cerebro-spinal fluid from the external auditory meatus. Two types of palsy are here to be distinguished, that which follows immediately upon the injury and is attributable to tearing of the nerve fibres, and that which is delayed in its onset for some days. The latter is caused by reactionary œdema in the facial canal, and affords an excellent prognosis under conservative treatment.

(*b*) During mastoid operations, the gouge may damage the facial nerve. If the palsy is apparent at the conclusion of the operation, surgical trauma is responsible and immediate operation to decompress and repair the nerve must be advised. If the paralysis develops during convalescence from the operation, the cause is generally pressure on the nerve from infective œdema, and local conservative treatment to the ear will suffice, together with a course of penicillin injections.

(*c*) During acute otitis media, a facial paralysis may develop. This does not indicate mastoiditis, but calls for the most careful treatment of the acute infection by myringotomy and penicillin injections. Some authorities state that this complication

is becoming more frequent since sulphonamide treatment was instituted. Facial paralysis developing during a chronic suppurative otitis media is of more sinister import. It indicates that the bony walls of the facial canal, usually in the region of the oval window, have been eroded, and calls for early mastoidectomy and decompression of the nerve.

(*d*) The pathology of Bell's palsy is unknown. The disease attacks persons, who are otherwise in perfect health, and post-mortem material is not therefore commonly available for study. An œdema of the nerve in the facial canal, together with slight changes in the surrounding mastoid air cells, are common findings at operations designed to decompress the nerve. About 80 per cent. of the patients are well on the way to spontaneous recovery within two months after the onset. In the remaining 20 per cent., who show no signs of improvement at the end of the second month, operation should, be advised, as it is unlikely that they will eventually recover unaided.

4. *Facial nerve in parotid gland.* After the nerve has left the stylo-mastoid foramen it is liable to injury during infancy, either from the unskilful application of obstetric forceps to the head, or from an incision over the mastoid. The baby's mastoid process is virtually non-existent at birth, and the nerve lies very superficially.

Incisions in the face, as, for instance, for the removal of tumours from the parotid, are responsible for injury of some of the facial fibres. Carcinoma developing in the parotid gland may betray its nature by causing a partial palsy of the face.

TREATMENT.

1. CONSERVATIVE. Common to all cases of facial paralysis, irrespective of the cause, is the vital importance of preventing the paralysed muscles from being over-stretched. A wire sling, protected by a sheath of rubber, is looped over the ear, like the ear-piece of a pair of spectacles, and its lower end is hooked into the paralysed corner of the mouth, so as to elevate it. The dental surgeon can help by making a small dental splint, which fits on to the existing upper teeth or upper denture. This has a small spur-like projection which issues from the corner of the mouth, and so keeps it elevated.

Second only to this is the importance of maintaining a brisk blood supply to the paralysed muscles. This can be achieved by short wave diathermy, or by electrical stimulations of the muscles. The latter owes its beneficial effect purely to the fact that muscular contraction increases the blood flow.

2. OPERATIVE. Surgical exposure of the facial nerve is indicated urgently :—

(*a*) In palsy noted immediately after mastoidectomy.

(*b*) In palsy developing during chronic otitis.

It may be required after some deliberation :—

(*a*) In the recalcitrant 20 per cent. of Bell's palsies.

(*b*) Occasionally, where delayed palsy occurs after mastoidectomy or head injury.

The operation entails the performance of a mastoidectomy and deliberate removal of bone till the course of the nerve through the petro-mastoid is laid bare. That part of the nerve which runs over the top of the internal ear is not accessible to surgery. In recent traumatic cases, the nerve may be seen, with the aid of the operating microscope, to be indented by a spicule of bone or by blood clot. Treatment in such simple injuries consists of removal of the intruder, and affords an excellent prognosis.

Nerve Graft. When, however, a length of nerve has been so damaged that a gap exists between the two ends of the nerve, or where this gap is bridged by a swollen mass of fibrous scar, one's only recourse is to excise completely the damaged segment of the nerve, and to fill in the gap with a nerve graft obtained from the lateral cutaneous nerve of the thigh.

Nerve Anastomosis is employed if it is found that the local conditions in the ear do not permit of the successful insertion of a graft. The peripheral end of the facial nerve is sutured to a nerve bundle derived either from the hypoglossal or the glosso-pharyngeal. The results are discouraging, and the operation is gradually being abandoned.

Facial Slings of fascia or muscle can be inserted into the substance of the cheek by a plastic surgeon, when the passage of time and the presence of fibrous contracture convince the surgeon that all his previous efforts have been in vain. The angle of the mouth can be lifted, and the face is rendered more symmetrical, at least in repose.

HERPES OF THE GENICULAR GANGLION.

This has purposely been relegated to the end of the lecture on account of its rarity. Its theoretical importance is so great that one cannot afford to omit it altogether. Ramsay Hunt described herpes of the posterior meatal wall and of the central strip of the concha, associated in some cases with loss of the vestibular function, nystagmus, deafness and tinnitus. The facial nerve is stated to supply sensory fibres, by its connection with the auricular branch of the vagus, to the area involved in the eruption of so-called genicular herpes. This, and the associated labyrinthine upset, has led to the idea that herpetic infection of the genicular ganglion is responsible.

The case for the existence of herpes of the genicular ganglion is not proved, and one would be wise not to diagnose it without considerable deliberation.

"London Town"

THE arrival of three television experts in the Nursing School at the beginning of October, to assess the possibilities of televising aspects of the training methods adopted by Guy's Hospital, aroused considerable interest among those of us who were going through the Second Year training course. That interest increased to excitement when it was later learned that it had been decided to include a short story of Guy's in Richard Dimbleby's programme "London Town," to be televised on October 31st at 9.15 p.m. The original idea had been to engage actresses to play the parts of nurses undergoing training in the School, but on the advice of Sister Florence, Mr. Stephen McCormack, the producer of the programme, decided to make use of student nurses in the scenes, and have only one additional actress to undertake the longer speaking part, and two others to make brief appearances as a Sister and Head Nurse.

After discussion a draft script was agreed upon, and ten of us who were lucky enough to be chosen to take part with Sister Verhoosel accordingly assembled in the Colonade on the fine, sunny morning of October 19th for the filming of the outdoor scenes. These were to form the picture sequence covering a commentary by Richard Dimbleby on his visit to Guy's Hospital, ostensibly to see the remnant of the old London Bridge preserved in one of the courtyards and now used as a shelter for patients who are well enough to sit out in the open air. The nurses would be crossing the courtyard on their way to the Nursing School, attract his attention and lead him to wonder how their day is spent.

At this point the scene was to shift to the Revelstoke Department, where various practical classes were in progress, and the commentary was to be taken over by actress Tilsa Page, who played the part of a Second Year nurse and explained briefly the methods of practical training which were being demonstrated.

During his first visit to the Nursing School, Mr. McCormack had seen a bandaging practice class in progress, the erection of a steam tent, and a bed-making class. The part that had appealed to him from the televising point of view, was that in which a "patient" was supposed to have a fractured pelvis, and the making of his bed had necessitated the lifting of the patient by six nurses. These three items were therefore included in the story, together with a visit to the Gordon Museum in the Medical School and a scene showing a group of nurses viewing on the television screen an operation in progress. The story finished with a shot of Tilsa Page, having finished her second year course, in a ward on night duty.

All the indoor sequences were to be performed at the television studios at Alexandra Palace, where replicas of a corner of the Revelstoke Department, the Gordon Museum and a hospital ward were being built. In the meantime, Mr. McCormack arranged to hold several rehearsals of the programme in the Revelstoke Department. The studio space allowed would be small, and it needed some ingenuity on the part of the producer to arrange the different scenes in the best positions for continuity of the story. The first rehearsal was therefore in the nature of a "try-out" of the whole idea from the point of view of the positions of the players in the different scenes, the suitability of the dialogue, and the general effect. It took two hours of hard work on this occasion to go through the script, which was scheduled to occupy ten minutes of the forty-five minute programme. Subsequent rehearsals went far more smoothly, and we soon found that the programme could be completed comfortably within the allotted time.

At last the great day arrived, and two o'clock on the afternoon of October 31st found us " on the set " at Alexandra Palace ready for our first rehearsal under the glare of the arc lamps and the watchful eyes of the cameras. After one or two rehearsals we felt quite at home in the unaccustomed surroundings and had lost most of our nervousness over the coming evening performance ; and if our self-confidence needed further boosting, no better means could have been found than the services of the make-up artists, who transformed our complexions from those of the typical town-dwellers to something of the healthy glow of the South-Sea Islanders !

One advantage of television is that there is no difference between rehearsals and the actual presentation when performed in the studio, and so it was that our performance was just like another rehearsal. There was no fear of that stage fright associated with a first stage entrance, when one is suddenly conscious of a sea of faces across the foot-lights, and all the paraphernalia of television—the arc lamps, the cameras and the microphones swinging overhead—had lost their forbidding aspects during the course of the afternoon. So, once more, we went through the now familiar routine, not fully appreciating until it was over that this time we were being watched by a vast unseen audience.

The whole programme went without a hitch, and at ten o'clock we were on our way back to Guy's. The day we had all looked forward to so much was now almost ended. To all of us, however, the events of this day would be imprinted on our memories as a most enjoyable experience that we certainly would never have wished to miss.

F. C. PERRY.

X-Ray Improvements

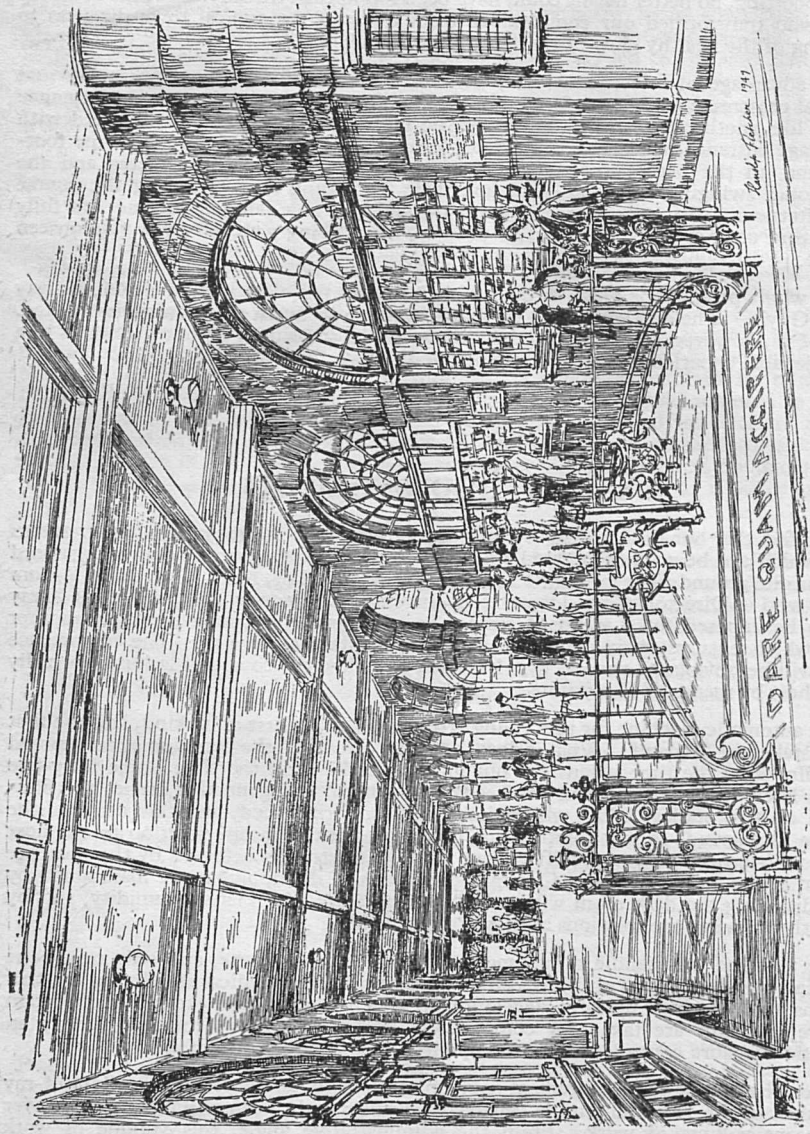
WE feel that our readers may be interested to know of the technical improvements which are being incorporated in the X-ray Department now being reorganised on the ground floor in Hunt's House. Dr. T. H. Hills, M.B. (Otherwise " Tom Hills ") who is Director of the Department, invented a device which enabled all X-ray films to be exposed for a standard time. In addition he has now invented another device which ensures their development for a standard time also. The importance of this will be obvious to anyone who has tried to follow the course of lesions especially in the chest by means of X-ray films.

The automatic machine for processing X-ray films is the first of its kind, and the first to be installed in England. What it does is to take care of all the handling of an exposed X-ray film from the time when it is put into developer until the time, some forty-five minutes later, when it is washed and ready to be dried. In general it carries the films forward on two endless belts, which move at a uniform speed, and this controls the time the film spends in any solution. To shift the film from one solution to the next there is an overhead pneumatic lift system which is electrically actuated by the presence of a film at the end of a tank. Constant conditions of development are maintained by air conditioning the datk room with a fixed temperature and relative humidity, and by constantly replacing the solutions as they are expended.

The machine will handle rather more than one film a minute, and only needs one technician to " feed it " with films. Its advantages from a medical standpoint are that the films will be given uniform development, which is of course extremely important when repeat films are taken for comparison. For chest X-rays there is already an automatic exposure control, and this completes the standardisation of chest X-rays.

When the new X-ray Department is completed it will handle practically all the X-ray films taken in the Hospital, and is capable of dealing with a considerable increase over the present volume of work. From the administrative angle, this volume of work would require at least two technicians normally, and the cost of the unit should be recovered in three to four years, apart from the additional saving from less wastage of chemicals and of films spoiled in the processing.

The Hospital Authorities have sanctioned the expenditure of quite a large sum of money on the apparatus and we can think of few things which must be so encouraging to their Staff as being backed up in this manner.



THE COLONNADE

Documentation

By REX LAWRIE, M.D., F.R.C.S.

AT the present time, when documentation and paper work of all kinds is increasing, it is, perhaps, valuable to consider the purpose and technique of medical records. Medical records are kept in the following interests :—

1. The Patient.
2. The Doctor.
3. Clinical Research.
4. Medico-legal.
5. Statistical.

The aims and technique of these types of record differ in some respects.

The Patient. The aspects of his case which are of the greatest interest to the patient are the prognosis and the treatment, and as in many instances the prognosis is much better not discussed with the patient unless he particularly asks, it is mainly for continuity of the correct treatment that the patient requires records kept. Of course, in the country as a whole, the vast majority of patients have no records of their treatment. It is a case of :

" What treatment did your last doctor give you ? "

"Some medicine."

" Oh well then I'll give you some tablets,"

and that is all that is really known about the treatment of that particular patient.

However, for patients whose care is important enough to take them to hospital, full records are usually worth keeping to control continuity of treatment, which may last over many years ; for example in orthopædic cases, where tuberculosis of the hip may start in babyhood and the treatment continue into adult life.

It is also desirable for the treatment by different departments to be co-ordinated and for records to be available when a patient transfers to a different hospital, as they have, unfortunately, every right to do whatever the cost.

After a long period of attendance in hospital, patients' notes sometimes become very voluminous, and this recalls the instance of a frail old lady attending for " Rep. tabs." On one occasion an enterprising registrar decided to trace back through the records to the origin of this prescription, and after a prolonged search which led him into the dusty bound volumes in the basement, he found that a physician who died in the last century had diagnosed her as a case of Struma when she was quite young, and had ordered thyroid tablets which had just been introduced, and they had been continued ever since.

However one can easily think of innumerable instances where records of treatment are vitally important to the patient.

The Doctor. The most important value of records to the doctor is in training him. When he is a student, routine full history and complete clinical examination teaches him indelibly the natural history of the various diseases he encounters. It also teaches the habit of quick methodical routine examination on which all clinical practice is based, and in addition it teaches him a bedside manner and an intimate knowledge of people. The records he keeps must also always include a personal account of progress and treatment ; and a full clinical record should contain such a clear picture of the patient that a person who never saw him could understand exactly what he was like and what happened to him. This is a very difficult thing to achieve, but it is worth attempting.

Keeping good records is largely a matter of habit and it is a habit well worth the initial effort needed to form it. It should be like a powerful conditioned reflex which makes it impossible for one to look at or do anything about a patient without immediately writing a note about it. Once this has become a reflex it takes very little time or trouble to do.

It is important to note principally facts which are not obvious from the temperature charts or other records kept and notes should be full enough to be informative. I remember one sheet of progress notes which read like this :—

17 June. Feels sick.
18 June. Sick.
19 June. Very sick.
20 June. Dead.

That is too brief.

Clinical Research. As a rule clinical research is focussed on comparatively circumscribed problems, and in that case it is best to attack the problem by working out a scheme set out as a proforma, which covers all the necessary questions and facts which must be elicited in every case for the purpose of the research. But this method cannot be effectively expanded to make all case-taking a mechanical affair of filling in a proforma, because the questions which must be asked in any particular case differ so much from many others that a conprehensive proforma is impossible, and the result can only be achieved by practice and intelligent use of one's experience. I recently worked in a surgical unit of 40 beds in a teaching hospital where an attempt was made to keep full in-patient records on every case. The records were all typed after considerable correction and editing, and set a very high standard on the whole. The method used first was to correct and edit students' histories, but as the students changed every three months the standard fluctuated accordingly and editing became impossibly cumbersome. Students' notes are inevitably not very suitable to be the sole permanent case records kept. We then changed to histories taken by experienced house surgeons, which in turn were edited by registrars, and the typed proofs recorrected afterwards. This system provided splendid notes, but it was necessary to have 3 registrars, 4 house surgeons, and 3 secretaries to do the work; the nates did not cover subsequent progress in the out-patient department and so were incomplete. This made the value of the record rather debatable, and the staff required was clearly more than any hospital could afford to provide for more than a small section of its beds.

Medicolegal. To be of value in evidence the notes must be written at the time and not concocted from memory, and the emphasis is on accurate detail and accurate examination. Sometimes it is important to note the state of mind of the patient, and in cases where an insurance claim may be made, details of the cause of injury, for instance, may be necessary. At the time of taking the history one must be aware of the possibility of being cross-examined on these details and take special pains to avoid loose phrasing.

Statistical. Documentary material of any kind can be subjected to statistical analysis, but the value of the result will depend on the completeness of the notes with respect to the conditions analysed. As a rule a high proportion of notes are unsuitable for whatever you are trying to find out.

Statistical analysis of manuscript material is very laborious. When I worked in Mr. Clarkson's Maxillo-facial unit we attempted to analyse 1,000 cases (quite a small number) of broken jaws, in respect of some 40 facts about each case. This evidence had to be extracted from the typed case-records, and the first coded transcription of the facts covered 79 pages of foolscap. In breaking this material down into sub-groups of different sites and types of fracture, all of it had to be copied out at least ten times in different orders. In larger series this kind of classification becomes impossibly laborious.

It may be largely overcome by entering the necessary facts in code on the sides of a card. The simplest method is to use hand-punched holes on the edge of a card, each hole in a particular position indicating a particular fact. Punch cards are a familiar sight in this hospital as the Department of Anæsthesia is using them for an investigation it is undertaking. By this method any combination of the facts recorded can be selected from the cards without copying them out again. The drawbacks of this method are that it is laborious and costly when large numbers have to be handled, and errors in punching are not easy to check. The latest method of indexing large series of cards is to use a card-punching machine which is exceedingly quick and the machines also file and sort any combination of facts required very rapidly. In addition errors in punching are at once detected by a very ingenious method: Every card is punched on two different machines, set so that the two holes do not exactly coincide; the second machine converts every round hole into an oval hole and a correctly punched card will thus have only oval holes. Any incorrect punching will appear as a round hole and there is a machine which picks out and marks all the cards which have any round holes on them so that they can be redone.

Of course, before facts can be punched like this they must appear in the notes; then be coded by a skilled transcription clerk; they are then punched by an unskilled punching clerk who punches them extremely quickly by a machine rather like an electric typewriter. The filing problem is solved by this method but what remains unsolved is the choice of facts to punch, and the problem of having good notes which contain all the facts chosen.

Installation of this machinery might seem very costly, but it can be hired from the manufacturers at a rent which includes maintenance and compares very favourably with the cost of the salaries of the clerical assistance it saves. Besides it is never ill and doesn't have to have annual holidays with pay.

Ordinary accounting machinery, such as is used by big firms, is used for medical records without special adaptation and can also be used for accounting and administrative purposes about the hospital.

Perhaps the justification of this brief résumé of the methods and purpose of keeping and filing medical records is to emphasise that whatever the machines can do can only be done if they have good notes from which to work. What we mean by good notes are notes which convey a true account of all that happens to the patient, his history, his examination findings, his special tests, his progress, and a detailed account of his condition on discharge; and besides containing an account of the objective facts of his condition they must convey the condition of the patient from the patient's point of view: whether he feels better, can do more, or has lost any of the symptoms he had when he came in. These are the true criteria by which we must judge the success of treatment.

The Old Hostel

Tucked away behind the Dental School and to the west of Guy's House lies the Old Hostel. It is a curious place, strangely reminiscent of some habitation in a Dickens novel. It is delapidated, the rooms are small, the walls are thin. Light occasionally struggles through the soot and smoke showered upon it by the famous Guy's Chimney, more often it never succeeds. The inhabitants of the Old Hostel are Students of all Years. They are an odd bunch. I know them well. I like them, but My! they are odd. Indeed some of them have taken on characteristics as Dickensian as their surroundings. They love to eat gargantuan home-cooked meals and sleep gargantuan sleeps (if there be such things). What they drink is nobody's business. They are independent to a man. Their rooms, they will thank you, are their castles. You may come in; anybody may; but you will remember their rooms are private and kindly tap first. Indeed, we do not see how such a curious Hostel, which is so drab, can remain so attractive; except perhaps that like Chinatown or Lant Street, its very drabness gives it character. That, or possibly its atmosphere of freedom; I do not know. The Old Hostel is indeed difficult to understand. In fact, you will never understand it unless you meet the beloved white-haired character known to all the world as "Sophie"; a character who rules over them and whose lightest word is law amongst the "young gentlemen," for this is the way that "Sophie" reminds them of what they ought to be.

"Pulse"

WE are glad to note the reappearance of "Pulse" after some months lapse. Our more distant readers will not know of this publication which is a Wall Newspaper appearing from time to time in the Medical School entrance. "Pulse" is a peculiar journal. Sometimes we envy it. It varies considerably from edition to edition and from editor to editor. The personality of the editor leaves a heavy imprint (we almost said footprint) upon its nature. Some have been "left-wing," some "right-wing," some independent (very). All prefer, if they can, to remain anonymous; anonymous, that is, for as long as possible. A new editor has taken over and in wishing him success we must add that if he, like his competent predecessor, can some day hand it on to someone else having fought neither Duel nor Law suit, we shall consider he has done well.

Correspondence

Information

SIR,—I hasten to reply to your correspondent, Mr. Leonard Jacobs, who voices the "unhappy bewilderment" amongst the students resulting from the lack of information about the erection of a bookstall in the grounds of the Hospital.

This project has been under discussion for such a long time, over twelve months, that I was under the impression that it was common knowledge that a decision had been made to go ahead. For any lapse therefore is not informing the student body through the *Gazette*, I apologise.

The Governors of the Hospital approached Messrs. W. H. Smith & Son, Ltd., some time ago with a view to improving the supply of daily papers, periodicals, etc., to the patients in the wards. After considerable discussion, Messrs. W. H. Smith offered to erect a bookstall in the grounds of the Hospital for supplying these articles to the wards, and in addition, providing a service for visitors and staff.

After consideration by the House Committee and the Board of Governors, an approach was made to the Ministry of Health, and their approval of the scheme obtained.

Messrs. W. H. Smith & Son, Ltd., were then asked to submit detailed plans, which were modified by the House Committee and subsequently approved, as was the material of which the shop was to be built.

The shop is now in the process of erection and it will be seen that very careful study has been given to all aspects of the scheme. The arrangement is in the nature of an experiment on both sides, and I trust that, as your correspondent fears, it will not in after years dim the memories or inhibit the affection and respect which Guy's men feel for their Hospital.

Yours, faithfully,
W. D. DOHERTY,
Superintendent.

The Editor,
Guy's Hospital Gazette.

Clubs' Union

SIR,—Mr. Large's efforts to inform members of the Clubs' Union of the financial affairs of that body will certainly be doomed to failure if his letter is his only word on the subject. Though it is possible there are members so ill-informed as to derive news from his note, the majority surely are aware of his points and are in darkness only as regards the meaning of such phrases as "a not inconsiderable sum of money."

Had his letter been prefaced with a full balance sheet it would have carried more weight.

What methods are being used to counteract the financial loss? No statement has been issued on the economies required of us, no report published on the decisions taken at the October meeting. Are we merely to accept the decisions of the Council or are we to be fully informed of their problem and then asked to assist in spending economically, the money we provide? The latter seems to be preferable.

Yours, etc.,
W. E. DOBSON-SMYTH.

Dental Dinner

SIR,—In reply to your correspondent, "Happily Married," I should like to point out that the Dental Dinner is for all members of our Hospital Dental Society. Included in this Society are all students at the school.

"Happily Married" is no doubt aware that during the past two years there have been women students at the School. Surely it would be a most unjust policy and one not wanted by the majority of old Guy's Men if we should exclude them from the Dinner.

Yours faithfully,
M. J. QUELCH,
Hon. Sec. Dental Society Dinner.

SIR,—When the Dean of the Medical School welcomed new students in 1947 he said that it was the first time women were present, and the last time special reference need be made to their presence. But " Happily Married " has commented upon their attendance at the Dental Society Dinner. He regrets this, and many who have known the old character of the dinner will share his regret.

The women are not insensitive to this change, and it was with diffidence and under persuasion that they first attended the dinner. But in a few years there will be qualified women who will welcome the opportunity to meet men and women who were their student colleagues, and will look forward to the Dental Society Dinner.

Many more changes than this have occurred, and this letter gives me a chance to express appreciation of the courteous reception accorded to the first women students. To staff and students our thanks are due—long overdue in fact—for receiving us so graciously into the academic and social life of the hospital.

Yours, etc.,

DENTAL STUDENT.

Guy's Hospital; S.E.1.

The New Guy's

SIR,—On reading the account in the *Gazette* of the meeting to discuss the plans for " The New Guy's," one was glad to observe the importance attached to the preservation of Guy's House, and heartened that the idea, at present little discussed, of using it for the accommodation of staff was mentioned.

There is much ground for criticism of the present arrangements. The Residents will clearly need new quarters, as will the Registrars for take-in weeks and for some permanently. For students both preclinical and clinical, whether or not on take-in, the doubtful quality of " digs " scattered over half London and the certainly squalid surroundings of the Hostels are inimical to work both in wards and with books and to social and club activities. Furthermore, many qualified men working for higher examinations find accommodation difficult and expensive.

Surely the preservation of Guy's House and its historical and traditional value could be most easily and effectively achieved by its use for the accommodation of those who will be carrying on these traditions.

Guy's House clearly needs considerable expenditure for long term preservation for any purpose, and before buildings of such distinction are destroyed, it is hoped that the possibility of its economical conversion into a College, including dining hall, reading room and bed-sitting rooms, etc., to house thirty-five residents and perhaps a hundred and fifty students and post-graduate men, will be carefully considered.

To preserve and enrich the old by satisfying a present need for better accommodation of a College would add much to the farsighted plans already disclosed.

Yours, etc.,

E. F. SOOTHILL.

Christmas Tea Party

SIR,—The Landon Children's Tea Party will be held in the Out-patients' Department this year at 3.30 p.m. on Christmas Eve, at which 200 children will be entertained.

In the past it has been customary to appeal to business firms in the neighbourhood for subscriptions towards the cost of this annual event. Under the present regime, hospitals are not allowed to appeal for funds, but there are many members of the Hospital Staff who have helped this cause in the past, and I have no doubt would like to continue to do so.

This tea has been an annual event since 1897 and any member of the Staff will be welcome who cares to come and see the entertainment in progress.

Yours faithfully,

PHYLLIS E. BIRD,
Hon. Secretary,
Landon Tea Fund.

A Protest

SIR,—I wish to protest against the manner in which Wednesday afternoons have been filled up with various teaching courses. The Hospital has a reputation in the field of sport which must be upheld and the free afternoon in the middle of the week is invaluable as a time for getting some fresh air and doing some training. But if members of hospital sides go to Honor Oak Park for their various games they find that they miss parts of a number of courses, some of which are compulsory.

Most students will agree with me that we work quite hard and it is with no wish to avoid work that the plea for a free Wednesday afternoon is made. I believe that it is important for the health of every one to be able to have two hours of fresh air in the middle of the week. And, after all, that is not much to ask. If we are in a position to be able to get exercise then we should take advantage of it.

It would not be too difficult to alter the time-table a little to have Wednesday afternoon free. If the Pathology Lecture and Demonstration, the Wednesday afternoon Fever Course and the Public Health Visits could be slightly rearranged, a large proportion of clinical students could take part in mid-week games. At present their attendance elsewhere makes this impossible. Cannot things be arranged otherwise ?

I am,

Yours, etc.,

W. G. DAVIES.

NOTE BOOK

Sporting Celebrities

IT is probably not generally known by Guy's people—old and new—that we have among our present students two Olympic Games representatives.

A. S. F. BUTCHER rowed for Cambridge in 1947 and after coming to Guy's in October of that year he rowed for the Thames Rowing Club at Henley in 1948. That year he was in the teams which won the Grand Challenge Cup for VIII's and Stewards' Challenge Cup for Coxswainless IV's, and later rowed with success in the Coxswainless IV's in the Olympic Games.

More successes followed at Henley again in 1949 and now he has been chosen for Great Britain for the Empire Games in New Zealand early next year.

P. H. KENDALL has been at Guy's longer than Butcher, and he has represented Great Britain as a swimmer in the 100 metres men's free-style in the Olympic Games. He is a former British 100 yds. free-style champion (in 1947) and has been runner-up in 1948, 1949. Kendall also holds all the records for all distances in the Surrey County swimming championships. He, too, has been chosen to go to New Zealand for the Empire Games.

Our congratulations to both these students on their achievements and may good fortune go with them both.

Two weeks ago the Hospital received a visit from an inspecting body from the University of London. This happens every 10 years. A whole day was spent touring the Hospital. After lunch a number of the visitors met a dozen or more students. There then took place what might politely be described as an " informal discussion." Actually, at least in our corner of the room it became a good old argument which was much more enjoyable. Perhaps the biggest surprise and, in a way, one most indicative of the topsy turvey state of affairs with which both University and Hospital have to contend in thse post-war years, was when, to their mutual astonishment, the senior member of the inspecting body and a junior student were brought face to face having last met as friends and contemporary undergraduates at Oxford.

Book Review

Gray's Anatomy. Edited by T. B. JOHNSTON and T. WHILLIS. 30th Edn. Longmans. *Price* 84*s.*

It is said that Guy's can claim so little responsibility for having reared the two present editors of this book, two Professors of Anatomy who have set a standard of teaching which is not only unsurpassed in this hospital, but which we doubt could be surpassed anywhere that anatomy is taught. We may, however, have justifiable and unbounded pride in having claimed them from the far north to grace our school. Seven of the thirty editions of Gray's Anatomy have come from the department at Guy's, under the editorship of Professor Johnston, the last three in co-editorship with Professor Whillis. All these, and not least this last one, cannot but add lustre to the name of the medical school whence they were launched.

This book remains the ultimate authority on anatomical facts. "Gray says. . . ." is irrefutable. In this capacity the book must have its place on every practitioner's shelf. For the understanding of the subject it is second to none for the student, particularly as regards embryology and neurology. As a production it does enormous credit to the editors, their artists and collaborators, and the printers and publishers.

In this edition, which has been completely reset, despite the insertion of new matter, restraint on growth has been exercised by careful pruning, chiefly by means of including details of surface anatomy in the appropriate sections rather than consolidating them in a section of their own. There are many new illustrations.

H.A.R.

Guy's Diary

ACADEMIC

December

Exhibition. Surgical Department. "The Maintenance of Nutrition."
5th. 1.00. Dr. Rink. Clinical Lecture. "Uses and Abuses of Pentothal."
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
6th. 1.00. Mr. Blackburn. Clinical Lecture. "Surgery in Emergency and Emergency in Surgery."
8th. 1.00. Mr. Wass. Clinical Lecture. "Pathological Discharges from the Nipple."
4.30. X-ray Demonstration. Gordon Museum.
9th. 2.15. Medical Department. Combined Round. Preclinical Classroom.
10th. 10.00. Surgical Department. Mr. Ronald Reid, Essex County Hospital, Colchester. Departmental Round. Clinical Theatre.
11th. 1.00. Dr. Hardwick. Clinical Lecture. "The Investigation of Dyspepsia."
12th. 1.00. Mr. Carter Brain. Clinical Lecture.
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
5.00. Department of Child Health. Film Show. Anatomy Theatre.
13th. 12.00. Medical Department. Neurological Demonstration. Preclinical Classroom.
14th. 4.45. Guy's Science Club. Dr. H. E. Holling. "Compensatory Mechanisms to Anoxia." Staff Common Room. (Tea 4.30).
15th. 1.00. Mr. Eckhoff. Clinical Lecture. "The Disc Lesion."
4.30. X-ray Demonstration. Gordon Museum.
16th. 1.00. Dr. Mann. Clinical Lecture. "Pneumonia."
2.15. Medical Department. Clinico-Pathological Meeting. Pathology Lecture Theatre.
19th. 1.00. Mr. Cook. Clinical Lecture. "Functional Uterine Hæmorrhage."
3.30. Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.

OTHER ENGAGEMENTS

December

7th. Association Football XI. *v.* St. Thomas's Hospital 2nd XI. (H.O.P.).
Association Football U.H. *v.* London University. (Away).
10th. Rugby XV. *v.* Old Cranleighans. (Thames Ditton).
Association Football 1st XI. *v.* Bank of England. (Away).
Association Football 2nd XI. *v.* Bank of England. (H.O.P.).
Hockey 1st XI. *v.* Metropolitan Police. (H.O.P.).
Hockey 2nd XI. *v.* Metropolitan Police. (Away).
Hockey 3rd XI. *v.* Wallington. (Away).
13th. 5.00. Dental Society. Mr. G. E. Wade. "Legal Risks in Dentistry." Dental Lecture Theatre.
14th. Association Football U.H. *v.* Army. (Away).
17th. Rugby XV. *v.* Moseley. (Moseley).
Association Football 1st XI. *v.* Old Lyonians. (Away).
Association Football 2nd XI. *v.* Old Lyonians. (H.O.P.).
Hockey 1st XI. *v.* West Herts. (H.O.P.).
Hockey 2nd XI. *v.* West Herts. (Away).
Hockey 3rd XI. *v.* West Herts. (Away).

Sport and Hospital Information

RUGBY

Results :

Nov. 5th.	*v.*	Old Blues.	Lost 0—16.
Nov. 9th.	*v.*	Cambridge Univ.	Lost 0—9.
Nov. 12th.	*v.*	Birkenhead Park.	Lost 6—14.
Nov. 19th.	*v.*	Rosslyn Pa-k.	Lost 5—17.
Nov. 21st.	*v.*	University College, Dublin.	Lost 11—20.
Nov. 26th.	*v.*	Old Whitgiftians.	Drew 3—3.

In a rather heavy period of games the Guy's team did enough to shake the confidence of its warmest supporters. It appeared that they were unable to win. Yet at the end there is good reason for hope that the team will begin to win. The side has been handicapped by the loss of A. C. de B. Ecksteen and D. le Clus through injury, but their reserves have given good accounts of themselves.

The game against Cambridge University was excellent. For the first half it remained even with the Guy's forwards just getting the measure of the heavy Cambridge pack. Eventually, in the second half, the weight and pace told and the University crossed for three tries.

At Birkenhead a very strong wind blowing down the pitch was the dominant factor in the match. Guy's played against the wind and emerged at half-time, worn out and 14 points down. Although they pressed hard in the second half the only score was two lengthy penalty goals by Davis.

The Rosslyn Park game did show cause for hope and the side was much improved in its attacking play. This assertion may seem odd in view of the result but is none the less true. The Guy's for wards were lively and obtained a great deal of the ball. The backs handled well and ran hard but were without luck. B. M. Gray scored the try from a quick heel in the loose. It was converted by Davis.

The following Monday against University College, Dublin, saw an apathetic pack completely beaten by the Irish forwards and only grand defensive work kept the score to 20 points. Guy's scored a try through Bellis after some good passing, and Davies converted this and kicked two penalty goals.

In the last game against the Old Whitgiftians the team produced some delightful rugger. The forwards were lively and the hooking of Robinson was first-class. The backs, rearranged early on owing to an injury to Howells, held the ball and ran well. Gray scored an unconverted try in the corner. At the end of the game the Old Boys replied with a penalty goal. It was a fast exciting game with rugger of a high order.

UNITED HOSPITALS REGATTA

The United Hospitals Regatta, held at Putney on November 16th, started after some delay while waiting for the fog to clear.

Guy's entered for three events. In the Senior VIII's the crew was drawn on the inside station against Bart's and London, and was eliminated after a gruelling race. The IV. entered for the Junior IV's and did well to beat St. Thomas's in the first heat, though being beaten by the eventual winners, St. George's.

Five members of the Rugger Club, none of whom had rowed before, appeared in garments ranging from top hats to pyjamas, and broke an oar in their herculean but unrewarded efforts.

The crews were as follows :—

Senior VIII. : C. C. Bull, R. C. Francis, J. P. Warren, R. C. C. Thompson, M. W. Potts, E. P. W. Tatford (Capt.), G. A. Taylor, J. G. P. Hunt, D. M. Middleditch (Cox).

Junior IV. : J. P. Bass, J. McKenna, H. Chatfield, K. A. Hillard, J. P. Warren (Cox).

Rugby IV. : H. Riddolls, W. Lung, M. Boyd, W. P. N. Moore, J. Willis (Cox).

ASSOCIATION FOOTBALL

Guy's *v* Old Latymerians

At H.O.P. Lost 2—4.
19th November, 1949.

Since the start of the United Hospitals A.F.C. fixtures, every Wednesday to which Guy's send seven or eight players, the 1st XI. has been playing with a lathargic air, whether this is coincidental or not is open to question. Suffice it to say that this coincidence happened also last season.

Old Latymerians came to H.O.P. with an unbeaten record and after five minutes play it seemed that Guy's might terminate this run. Sturdy took full advantage of a defensive slip to put the Hospital one up with a good shot. A few minutes later he nearly repeated this goal and was extremely unlucky to see his shot graze the upright on the wrong side. After a period of indifferent play, Old Lats. equalised with an overhead shot that surprised the Guy's defence. At half-time the scores were level at one all, but this state of affairs didn't last long as Phillips, the Old Lats. inside forward, scored in the first minute with a shot into the far corner of the net after the ball had been headed to his foot by a Guy's defender. The visitors quickly increased their lead with a magnificent shot from the same live-wire Phillips.

Harris, the Guy's centre-forward, broke away and although his finishing shot was off the target it was blocked by an Old Lats. back and Leckie running in made no mistake.

Just on time the visitors added a fourth goal which completed the scoring.

It would be charitable to say that perhaps three members of the Guy's side were suffering the effects of the Dental Ball of the previous evening, for the rest silence is golden.

Team : A. Fearn ; D. Lipington, P. Holloway ; D. Matthews, D. Allan, A. Swift ; B. Cornhill, E. Newton, D. Harris, C. Leckie, E. Sturdy.

Guy's 2nd XI. *v.* Old Latymerians 2nd XI.

Away. Lost 2—5.
19th November, 1949.

Guy's 1st XI. *v.* Bank of England 1st XI.

Away. Draw 0—0.
26th November, 1949.

Guy's opened the play as though they were going to run up a decent score but many early opportunities were lost due to a very greasy ball and a hard tackling defence.

From a corner by Cornhill, Sturdy collected the ball, tricked two defenders, and sent in a shot that looked all the way a goal, but the home custodian brought off a magnificent save. As the first half wore on the game evened up and both sets of forwards had their chances. However, in the Guy's defence Bishop playing in his favourite position at right back and Wylie playing his first game for the senior team at left back were competent to deal with all attacks.

In the second half with Guy's half-back line feeding the forwards, the Hospital side dictated play and only excellent work by the home goal-keeper plus a little hesitance in front of goal denied the visitors taking both points.

The display by the Hospital side showed enthusiasm and determination that has been lacking of late. In fact this display when compared with that of the previous week was as champagne to port type wine.

Team : A. Fearn ; M. Bishop, J. Wylie ; D. Lipington, D. Allan, A. Prince ; B. Cornhill, D. Matthews, D. Harris, E. Newton, E. Sturdy.

HOCKEY

Resuots :

Saturday, November 19th.

Guy's I. *v.* **R.N.C.** (Greenwich)	Won 7—2.
Guy's II. *v.* **Spencer III.**	Lost 0—1.
Guy's III. *v.* **Spencer IV.**	Won 5—2.
Guy's IV. *v.* **Woking II.**	Lost 0—14.

Saturday, November 26th.

Guy's I. *v.* **Lensbury I.**	Won 2—1.
Guy's II. *v.* **Lensbury II.**	Won 3—1.
Guy's III. *v.* **Lensbury III.**	Lost 0—2.

BOXING CLUB

The Club will be boxing against the Metropolitan Police on Tuesday, 13th December, at 7.0 p.m., at the Streatham Baths.

The following gentlemen have been selected to represent the Hospital :—

A. M. Atkinson	W. M. Sheeran (Capt.)
M. Bishop	H. N. St. John
D. Clarke	R. C. C Thompson.
B. Cremin	W. Watson
M. Halamandres	T. M. Winstanley
J. Kirkbride	

Mr. G. A. R. Winston, the Librarian, has kindly offered to obtain tickets for anyone who wishes to attend this Competition.

The Open Tournament in aid of the Pavy Gymnasium, to be held later in the season, will be the return match against the Metropolitan Police.

HOUSE APPOINTMENTS

1st DECEMBER

ASSISTANT HOUSE SURGEONS.

To Mr. Slesinger – Mr. A. M. Platt
„ Mr. Wass – Mr. J. A. Loeb
„ Mr. Blackburn – Mr. M. C. Gilbert
„ Mr. Lawrie – Mr. F. G. Ellis
„ Mr. Glover – Mr. J. A. Payne*
Appointed for six months, first three months as A.H.S.

OUT-PATIENT OFFICERS.

Mr. J. D. Morris
Mr. J. F. Soothill
Mr. W. J. C. Symonds
Mr. O. L. Thomas
} 3 months.

HOUSE SURGEONS.

To Sir Heneage Ogilvie (6 months) Mr. C. J. G. Menzies
Mr. Massie (3 months) Mr. D. O'Keeffe*
Mr. Eckhoff (6 months) Mr. J. Crossley
Mr. Atkins (3 months) Mr. N. H. Porter

HOUSE PHYSICIANS.

To Sir John Conybeare and Dr. Hardwick (3 months) Mr. J. H. Evans, Mr. R. W. Glenn
„ Dr. Boland and Dr. Baker (6 months) Mr. T. B. Brewin, Mr. G. W. Scott
„ Dr. Hampson and Dr. Kauntze (6 months) Mr. A. J. Salmon, Mr. I. E. Evans
„ Dr. Douthwaite and Dr. Mann (3 months) Mr. J. D. Williams, Mr. R. D. Allen

RESIDENT OBSTETRICIANS.

1. 7.49—31.12.49 Mr. A. W. Banks*
1. 9.49—28. 2.50 Mr. J. A. Bulleid*
1.11.49—30. 4.50 Mr. T. C. L. Parry*
1. 1.50—30. 6.50 Mr. K. A. A. Campbell*

NEUROLOGICAL HOUSE PHYSICIAN

Mr. T. R. L. Finnegan* (3 months)

CHILDREN'S HOUSE PHYSICIANS.

Mr. B. G. B. Christie (3 months)
Mr. R. G. Nicholson (6 months)

DERMATOLOGICAL HOUSE PHYSICIAN.

Mr. O. F. Conran (6 months)

† Subject to qualification.
* Ex-service Medical Officer.

GENITO-URINARY HOUSE SURGEON.

Mr. E. J. McGuire (6 months)

HOUSE SURGEON TO THE THORACIC UNIT.

Mr. R. McL. Brown (6 months)

OPHTHALMIC HOUSE SURGEON.

Mr. H. L. Backhouse* (3 months)

THROAT AND EAR HOUSE SURGEON.

Mr. H. E. G. Dyer (3 months)

RESIDENT JUNIOR CLINICAL PATHOLOGISTS.

Mr. A. T. T. Forrester
Mr. P. E. Prudhoe*
} To 31.3.50.

ORPINGTON :

ORTHOPÆDIC HOUSE SURGEON.

Mr. J. A. B. Jones.

EAR, NOSE AND THROAT HOUSE SURGEON.

Mr. D. L. Blundstone (3 months)

HOUSE SURGEON.

Mr. H. A. Hurwood.

SOUTHERN :

HOUSE SURGEON.

Mr. J. H. McL. Buckley.

HOUSE PHYSICIAN.

Mr. E. W. Melia.

JOYCE GREEN :

HOUSE SURGEON.

Mr. I. S. Moss.

PEMBURY :

CHILDREN'S HOUSE PHYSICIAN.

Mr. M. G. D. Davys*

HOUSE SURGEONS.

Mr. A. E. McLauchlan.
Mr. G. Canty.

HOUSE PHYSICIAN.

Mr. D. G. Chalmers.

* Ex-service Medical Officer.

APPOINTMENTS

Cook, Frank, M.B., B.S., F.R.C.S., F.R.C.O.G., Honorary Consultant Gynæcologist to the Queen Alexandra Military Hospital, Milbank, S.W.1

Clarkson, Patrick, M.B.E., M.B., B.S., F.R.C.S., Honorary Consultant Plastic Surgeon, Queen Alexandra Military Hospital, Milbank, S.W.1.

NOTICES

PASS LIST

UNIVERSITY OF LONDON

THIRD (M.B., B.S.) EXAMINATIONS FOR MEDICAL DEGREES.

October, 1949.

Honours.

†M. C. Gilbert *J. A. Loeb

*Awarded University Gold Medal. Distinguished in Pathology, and Hygiene and Forensic Medicine.

† Dintinguished in Applied Pharmacology and Therapeutics.

Pass.

E. Beswick
D. L. Blundstone
J. H. McL. Buckley
J. P. Crawford
J. D. Crowle-Smith
P. R. Dove
J. R. Greaves
K. M. S. Hume
H. A. Hurwood
L. Jacobs
P. G. W. A. Lommerse
E. J. McGuire
A. A. Mason
D. G. May
E. W. Melia
C. J. G. Menzies
J. D. Morris
I. S. Moss
P. T. C. Rowan
G. W. Scott
B. L. Whitaker

SUPPLEMENTARY PASS LIST

Part I.

H. M. Baird
A. G. Blyth
A. E. R. Buckle
J. C. Camac
P. Dinmore
J. Foley, B.Sc.
G. A. L. G. Glazebrook
R. Goulding, B.Sc.
R. C. Greenberg
T. S. Hart
J. M. Holden
J. W. Hughes
E. M. Hume
T. D. Kellaway
G. A. Lawrence
E. C. Lewis
M. Lewis
I. J. MacQueen
R. C. Michell
R. C. Nauth-Misir
T. M. Owen
J. B. Parsons
A. M. Reader
I. Rocker
P. R. Sowerby
D. E. Sturdy
L. Tann
M. G. Thompson
W. H. Watson

Part II.

B. L. Bisley
G. Canty
J. C. B. E. Carreras
J. T. Cecil
O. F. Conran
M. P. Coplans
J. R. Deacon
A. T. T. Forrester
I. G. Johnston
D. M. Lewis
R. L. Luffingham
M. Mason
D. S. Noble
J. A. Payne
G. F. M. Pierce
P. B. Poole
T. I. Rowland
I. A. W. Scott

Part III.

D. G. Chalmers
K. R. Heber

UNIVERSITY OF LONDON

Appointment.

Dr. Robert Knox has been appointed to the Chair of Bacteriology tenable at Guy's Hospital as from 1st October, 1949.

Teachers.

The following teachers have been recognised as Teachers of the University and assigned to Guy's Hospital Medical School:—

Anæsthetics: T. A. B. Harris, D.A.; W. S. McConnell, D.A.; E. H. Rink, D.A.
Radiology: T. H. Hills, M.B., B.S.
Medicine: Ralph Kauntze, M.D.
Surgery: R. S. Lawrie, M.D., F.R.C.S.
Obstetrics and Gynæcology: T. L. T. Lewis, M.R.C.O.G., F.R.C.S.
Children's Diseases: R. C. MacKeith, D.M.
Dental Surgery: J. W. Mansie, F.D.S.
Mental Diseases: T. A. Munro, M.D.

Scholarship.

The University Studentship in Physiology has been awarded to Ray Jesse Shephard.

ROYAL SOCIETY OF MEDICINE

The undermentioned Guy's Men have been elected Presidents of the Sections indicated:—

Epidemiology and State Medicine: W. H. Bradley, D.M.
Laryngology: R. D. Owen, F.R.C.S. Ed.
Odontology: F. N. Doubleday, F.D.S.
Pædiatrics: W. W. Payne, M.R.C.P.

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School for a **Scholarship** tenable for one year at the **Northwestern University, Chicago,** commencing in September, 1950. The Scholarship covers the cost of tuition fees and at the end of the course the holder will be eligible for the D.D.S. degree.

Forms of application may be obtained from the Dean, Medical School Office, Guy's Hospital, S.E.1. Closing date for applications is Tuesday, 31st January, 1950.

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School for the **Dental Travelling Scholarship.** The Scholarship will enable the holder to pursue a course at one or more Colonial or Foreign Dental Schools. The Scholar will normally be required to proceed abroad at such time as will enable him to commence the course in October, 1950.

Forms of application may be obtained from the Dean, Medical School Office, Guy's Hospital, S.E.1. *Closing date for applications is Tuesday,* 31st January, 1950.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the appointment of **Lecturer** in the **Pharmacology Department.** *The appointment will date from as soon as possible* after 1st January, 1950, and will be for two years in the first instance. Salary £800×£100 to £1,100, plus superannuation and family allowance. The initial salary may be fixed above the minimum of the scale according to the experience and qualifications of the candidate selected.

Forms of application obtainable from the Dean, and should be lodged in the Medical School Office not later than 30th December, 1949.

Applications are invited for the appointment of **Junior Assistant (Research) to the Director *of the Department of Surgery.*** *Appointment* will date until 30th September, 1949, in the first instance, at a salary of £550 per annum, plus superannuation and family allowance.

Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be forwarded to him together with the names of three referees not later than 20th December, 1949.

CHANGES OF ADDRESS

D. W J. Cullingford, M.B., B.S., The College, Guy's Hospital, S.E.1.
B. C. Morgan, M.B., B.S., 9, Guildhill Road, Southbourne, Hants. (Tel. Southbourne 1118.)
T. E. Oppie, M.B., B.S., 156, Westcombe Hill, Blackheath, S.E.5.
P. C. Shingler, B.D.S., L.D.S., 151, New Church Road, Hove, Sussex.
T. K. Walker, L.D.S., 162, Dyke Road, Brighton, Sussex. (*Tel. Preston 7757.*)

MARRIAGES

DORNHORST—KELLY.—On November 19th, 1949, Hubert Dornhorst, L.D.S., R.C.S., Sc., son of the late Doctor H. Dornhorst of Stoke-newington, N.16, and of Mrs. *G. Dornhorst* of Clacton, to Sheila, daughter of Mrs. G. Kelly and the late Mr. Kelly of Salisbury, S. Rhodesia.

EDS. {R.G. P.A.Z.

GUY'S HOSPITAL GAZETTE

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PASSIM

ANOTHER week will pass and Christmas will be here. For some time already the commercial interests of society have directed their efforts to the so-called festive season. To-day, in Aldous Huxley's words, " Christmas is an important economic event." Taken up with all the meretricious hum-bug we lose sight only too readily of what the commemoration really means.

To the majority of people the holiday offers a welcome and anticipated respite from their otherwise monotonous labours. To so many housewives it represents an aggravation of their rationing worries and ever more work in the kitchen. For others—farmers, transport workers, public-utility employees and, lest we forget them, doctors and nurses, it is very much a prospect of " business as usual." But there are certain folk for whom Christmas is a very special occasion and we refer thus to the children and those who find themselves in hospital. As far as they are concerned, Guy's will not fail in its duty. By custom, the wards will be gay with colour and decoration and the spirit will be that of hope and good cheer. In the Chapter House the walls will resound to the song and laughter of the Salomon's Centre party, while in Out-Patients there will be the usual exuberant gathering at the Landon tea.

Meanwhile, the true message of Christmas must not be forgotten. At the Hospital, services will be held in the wards and in the Chapel (details appear on another page of this issue). For many people of this century, however, the previously accepted Christian doctrine has so little to offer. Some may pity such an attitude ; others scorn it. The fact remains that among those numerous individuals without allegiance to any church or accepted faith there is no lack of philosophy or design for living. This may be expressed in various ways but the ultimate objective, in so many instances, is an appreciation, tolerance and understanding of mankind. To the doctor and the nurse such an approach to life is an essential pre-requisite of successful practice and Christmas, above all, is the time to renew the pledge of devotion and personal service. Let there be at this season of the year no little heart-searching on the part of everyone and a firm resolve to achieve what Eliot phrased as " peace on earth to men of goodwill."

THIS is an era of " crises." The popular press which exists as an almost exclusive source of information to such a large mass of the community regales its readers with formidable headlines referring to a succession of " crises " that beset practically every branch of human activity—from finance to sport, from food to films and from reticulocytes to sewage disposal. Not to be neglected in this respect the universities are now proclaiming themselves the victims of such a disaster. What is so extraordinary about these " crises " is that they all last so long, a feature at some variance with the precise meaning of the term, but no doubt this very inexactitude is yet another symptom of contemporary malaise.

What precisely is wrong with our higher centres of learning that they face impending dissolution to their intellectual existence ? According to the various authorities that are so happy to be consulted on this question there is no longer any liberal out-look. The narrow view prevails and everywhere scientists are committed to an almost inhuman pre-occupation with ever more specialised study. So great is the concern thus occasioned

that *The Times* has not only devoted a leader to this subject but has allowed its valued and envied correspondence columns to be filled with a veritable plethora of comments from all manner of people claiming to be interested. There is a deadly conflict, so we are led to believe, a guerre à la mort, between humanism on the one side and technology on the other. Now what happens in Oxford, Massachusetts, or Charlottenburg is not our immediate worry. But when someone accuses the medical faculties of being particularly at fault then it is that we rise in protest.

Here in London the life that the student leads is totally different from that enjoyed by the undergraduate in any of the older universities. The man in his preclinical years is admittedly denied so many of the delights that accrue from social intercourse with members of the other faculties. But to conclude from this, quite peremptorily, that the medical man is professionally centred to an undue degree is to betray irrational thinking and dismal ignorance. Indeed, among those at Guy's, we are prepared to wager that a wider variety of interests is to be found than would be encountered in any other single calling. As J. B. S. Haldane has so lately pointed out, it is probable " that the average academic scientist knows more of the by-ways of humanistic culture than do his colleagues on the Arts side concerning the main problems of science."

Still, there is no cause to be smug about the medical outlook. For the student, undergoing as he is a rapid growth and development both intellectual and social, the extra-academic facilities offer a stimulus as strong and important as any didactic teaching. The two influences, in fact, should be complementary. That is why we suggest that organised classes should be completely free from any taint of compulsion. Enforced attendance merely gives the indifferent lecturer a false idea of his own worth and encourages the signing of registers followed by the immediate withdrawal to more congenial surroundings. Let there be no mistake, we are not advocating any positive deletions from the time-table, but that students should be free to choose for themselves. The courses that are not adequately supported can be discontinued forthwith. The person that prefers his own methods or, perhaps, neglects to be taught at all will then reap an oppropriate reward. At any rate, the scope for individuality will be extended and students will at least cultivate the art of selection and discrimination.

But beyond all this another field remains practically undeveloped; that is the association between mentor and student not as regards the studies themselves but rather their place in relation to life as a whole. The advantages of the tutorial system are withheld from the London medical student. In the more "spacious" and less financially stringent days of previous generations a personal inspiration derived from that contact which was achieved by social entrée. Whereas before, the professional man could very often accommodate his apprentice in the home, to-day, as W. Cleveland Stevens has pointed out in his directorial address on this topic to the students of the Inns of Court, " very few members of the professional classes . . . have houses of their own—flats with a minimum of upkeep have taken their place."

Then again, the unifying effect of religion is no longer present. In this twentieth century we are a race of sceptics. Among those searching for a creed even the most eminent are numbered, a fact made plainly evident by the correspondence which followed the publication in the *Lancet* of the Archbishop of Canterbury's address at the Birmingham Medical School.

As with Christmas so with education, more is involved than material satisfaction. If the medical faculties are to remain beyond the impact of the " crisis " and if they are to progress still further towards the full expression of humanism, then we must ask still more of our teachers—that they should allow us not only to share their knowledge but also to ponder their ideals.

GUY'S representatives in America have conducted themselves with distinction. Mr. Brock's activities, in fact, have made headlines in the evening papers. His wife has written enthusiastically of her experiences at Johns Hopkins where she witnessed a most impressive ceremony in which the student nurses took part, the whole of the proceedings being conducted in the symbolic inspiration of Florence Nightingale.

IN a hospital as large as Guy's changes in the nursing personnel are almost a daily occurrence, but when Sister Grimwood left Front Surgery at the end of November, having served in that department for more than nine years, a major event took place. Her work there, especially in association with Mr. Clarkson, has given Guy's one of the most efficient casualty units in the country. May every success attend her in the Nurses' Home where she has taken up her new position.

At the same time a welcome is extended to Sister Henry who succeeds her on the Front Surgery.

ON Friday, 2nd December, a large party of students from St. Mary's Hospital was entertained at Guy's by the Students' Union. The visitors were given the opportunity during the afternoon to join certain of the teaching rounds and to watch various operations in progress, particularly those under the television camera. After tea they were invited to a film show and a lecture given by Dr. MacKeith Finally, a most attractive meal was furnished in the "Spit," Mr. Eckhoff taking the Chair. "A good time was had by all," and the only cause for regret was the impracticability, owing to difficulty of accommodation, of organising a dance as a culmination to the whole programme.

ANYONE using the underground passages at the Hospital, whether for business, pleasure, convenience or the black-market, will have noticed of late the array of brightly-coloured pipes that now adorn those erstwhile dismal caverns. Red, white, blue, yellow, black and orange can easily be distinguished. There must be a meaning behind all this, but exactly what it is no one appears to be sure.

The red and the blue—are they arteries and veins ?—may well have something to do with that mysterious research being conducted in the surgical department and, although it is not yet confirmed, there is good reason to believe that the yellow conduits find their way to the neurological department, though some say the venue is psychiatry in Snowsfields.

The other suggestion is much more seasonal—that the Christmas decorations have spread to previously neglected territory.

ON the book-shop site the builders have gained the upper hand. Following their reverse a week or so ago on a night, it will be remembered, when the residents had a party, four secure brick-walls have now been constructed. In the absence of any further Bacchanalian parties the scaffolding has also been completely restored. The prospect of it being torn up again and thrown of a heap in the midst of the site is both undesirable and unlikely.

ALL credit to Wilf Watson for his heroic deed befitting a member of the Hostel fraternity. Returning from a rugger match in Norwich he was startled by the cries of "Save her !" coming from a large crowd on the river bank. In the water a woman was drowning. Without more ado he removed first his coat, then his trousers and, finally his resplendent yellow waistcoat and thereupon dived to the rescue. Coming to the surface, somewhat stunned, he waded to the hapless victim. She, however, preferred to drown and vigorously opposed any interference with her proposed course of action. But the hero was undaunted. Making it perfectly clear that his aquatic exploits were by no means pleasurable indulgences he dragged the wretched woman to the safety of the bank.

The Annual Rugby Ball for the present season is to be held at the Hyde Park Hotel on Friday, 20th January, from 9 p.m. until 2 a.m. It is hoped that as many old Guy's men will attend as possible.

Double tickets, 2½ guineas, may be obtained on application to W. M. S. Boyd, Guy's Hospital, London, S.E.1.

Primary Tuberculosis and B.C.G.

By JOHN STEAD, M.R.C.P.

Part of a Lecture given to Post-graduate Students on 7th October, 1949.

DURING the past few weeks some of the nurses at Guy's have been vaccinated with B.C.G. (Bacillus Calmette Guérin) and before long many of the students and staff will also be vaccinated, so that this seems an appropriate moment for a discussion of its value and a description of the technique.

Before going on to consider B.C.G. vaccination it seems necessary to provide a background by summarising the behaviour of tuberculosis in its early stages. Though this is extremely complicated, some of the recent work done on the subject makes it a little more comprehensible.

Primary Tuberculosis.

It has been shown that there is an incubation period of 4–6 weeks between infection and the formation of a primary complex (local lesion and enlargement of regional glands) about 85 per cent. of which occur in the lungs. Infection is so widespread that by the age of 20, 80–85 per cent. of the population have had their primary infection, though, of course, in the great majority it causes no symptoms and is never recognised.

None the less it is becoming clear that primary infection is not the completely harmless process once thought but that a large proportion of cases of tuberculous disease develop in the months or years that follow it. The risk is apparently different at different ages, greatest in infancy, less during childhood and once again greater in adolescence and early adult life.

The ways in which the disease becomes manifest also tend to be characteristic of certain age groups. Thus infants relatively commonly develop meningitis as a complication of primary infection, never cavitating pulmonary disease. Adults commonly show pulmonary disease, seldom meningitis; while exudative pleurisy is often seen in young adults, seldom in children, never in infancy.

These several forms of disease tend to show themselves at different, though characteristic, intervals after primary infection. This is of the order of 1–3 months for meningitis, 3–8 months for pleurisy, 1–3 years for pulmonary and bone and joint disease, and 2–10 years for renal disease.

Concurrent with primary infection two other events take place. These are: (1) the development of sensitivity to tuberculin as shown by the positive Mantoux reaction which can therefore be used as an indication of whether an individual has been infected; (2) the acquisition of resistance to tubercle bacilli with increased ability to localise and destroy them. Without it every primary infection would continue to spread relentlessly. Thus, the Mantoux positives, once through the post-primary stage, have a lower incidence of disease than the Mantoux negatives. Hence the ban on Mantoux negative nurses working among cases of tuberculosis which has been in force at Guy's for some years.

Though tuberculous disease develops in only a very small proportion of those who have primary infections, there are about 50,000 new cases per annum in this country and so it remains the last uncontrolled bacterial disease and the greatest cause of death in young adults—a challenge to us all.

B.C.G. Vaccination.

B.C.G. vaccination, so its advocates say, provides a means of inducing a safe primary infection in tuberculin negative individuals such that they then become Mantoux positive and exhibit the increased resistance to disease shown by naturally infected individuals who have safely passed through the relatively dangerous post-primary period. They do not claim that it will prevent disease altogether, but that it will reduce the incidence to 1/5th or 1/7th of its former figure.

B.C.G. vaccine consists of a suspension of live bovine tubercle bacilli which have been attenuated by repeated culture on special media so that it has lost its virulence and can no longer cause disease in man or animals.

The original work of attenuation was carried out by Professor Calmette at the Pasteur Institute between 1908 and 1921. The cultures at present used in many parts

of the world are direct descendants of the original ones. Animal experiments, which have been confirmed, showed that the vaccine was effective in preventing disease in many species.

The use of B.C.G. as a prophylactic in human disease began in France in 1922, when it was given by mouth to children born into tuberculous families. Considerable claims were made for its efficacy and as a result Heimbeck, in 1926, began the inoculation of Mantoux negative nurses in Oslo, using the intracutaneous route which has since become almost universal.

Heimbeck also claimed a high degree of protection, though his results have been challenged. From then on the use of B.C.G. spread throughout Scandinavia where it is now considered an indispensible part of the vigorous anti-tuberculosis campaigns that have been carried out in those countries.

During the 'thirties, large-scale studies were made in other European countries and North and South America, but unfortunately criticism can be brought against most, if not quite all, of them. Either there is no control group or the control group is not exactly comparable, or vaccination has been used as one among several simultaneous methods of investigation or treatment. None the less a considerable amount of circumstantial evidence has accumulated in favour of B.C.G., even if this does not provide statistically satisfactory proof.

Here, in summary, is an example of the evidence in which chance provided an almost perfectly controlled experiment. In 1943 there were in a certain Danish State school 368 girls between the ages of 12 and 19, of whom 130 were naturally Mantoux positive, 133 had been B.C.G. vaccinated and had as a result become Mantoux positive, while 105 had recently entered the school and were known to be Mantoux negative.

A number of cases of minor illness broke out at this time, which were proved to be due to tuberculosis. With some difficulty the source of infection was shown to be a teacher who had a cavity at one apex and was sputum positive. All the affected children were taught by her in a blacked-out classroom. Hyge Mantoux tested, X-rayed and followed up these girls and his most recent report gives the following figures (June, 1949) :—

	Total	Exposed	Mantoux Conversion	Primary lesion demonstrated (X-ray and/or bacilli)	Pulmonary tuberculosis
Naturally Mantoux+'ve	130	105	—	—	4 cases
B.C.G. vaccin. Mantoux+'ve	133	106	—	Nil	2 cases
Naturally Mantoux—'ve	105	94	70	41	11 cases (1 death)

Among the Mantoux negatives there were 8 cases of Erythema nodosum, 10 cases of pleurisy, 1 of pericarditis and 1 of peritonitis.

On such evidence B.C.G. is being increasingly accepted throughout the world, so that, for instance, W.H.O. can claim to have vaccinated 6½ million Europeans since the war. So far very little of this work has been done in England, though we have provided more than a fair share of the criticism : and it is to be hoped that we shall now undertake a large-scale investigation to provide a conclusive answer one way or the other, though one must not underrate the difficulties of doing so in a disease as complex as tuberculosis using a preventive method which is certainly not absolute in its effect.

TECHNIQUE.

B.C.G. vaccination of tuberculin (Mantoux) positive individuals is undesirable, firstly because it is of no value, secondly because it may result in the rapid development of unpleasant though harmless reactions. Except in the case of new-born infants, who are all tuberculin negative and can therefore be vaccinated without further ado, the first stage is tuberculin testing. This raises its own problems. If the test is too "weak" some infected individuals will be missed : if too "strong" non-specific reactions occur.

The following suggestions are based on Scandinavian practice :—

(1) Children under 12, Vollmer or Moro patch test :
Positive—a papular eruption after 72 hours.

(2) Adults—(*a*) Mantoux 1 : 10,000 read after 72 hours.
If negative : (*b*) Mantoux 1 : 1,000.
Positive : more than 10 mms. of infiltration after 72 hours.

Negative reactors are vaccinated, the dose being .1 cc. (containing .12 mg. vaccine) intracutaneously, either over the deltoid or on the outer side of the thigh. Our supplies of vaccine are to come from the State Serum Institute, Copenhagen, and must be used within a week. Being a live vaccine it requires careful handling to avoid contamination.

The reaction to B.C.G. varies considerably. Generally speaking, nothing is visible at the site of inoculation for three weeks when a superficial induration about the size of a sixpence gradually develops, and may go on to form a minute dry ulcer. The regional glands may undergo slight enlargement (the glandular component of the B.C.G. primary complex) but this is seldom troublesome, and there is no constitutional upset.

The local reaction heals slowly leaving a scar like that of small-pox vaccination after six months. The nature of the reaction should be recorded 6–8 weeks after vaccination, and at the same time tuberculin testing may be repeated. It is likely to reveal 1–2 per cent. who are still negative and therefore need re-vaccination.

In the normal course of events B.C.G. immunity will be reinforced by exposure to tubercle bacilli, but if this does not happen it will gradually wane so that re-vaccination may be required in between 5 and 10 years.

Among the negative reactors at the first test will be a very small percentage (between 1 and 5 per thousand) who are incubating their natural primary infection. If these are vaccinated they will react rather violently. This can largely be avoided by isolating all the Mantoux negative group from known sources of infection for six weeks and then repeating the test, but if this is impossible, these reactions are accepted in the knowledge that they are harmless.

Similarly—and this applies particularly to babies born into tuberculous households—B.C.G. immunity probably takes 6 weeks to develop so that the subject should be isolated from any chance of infection for that period after vaccination.

This account is enough to indicate some of the difficulties that arise in carrying out a large-scale B.C.G. campaign which in any case requires 2–7 attendances and 1–5 injections per person and good records—expensive, time consuming and rather unpleasant. Judging by our attitude in the last twenty years, B.C.G. vaccination is not likely to be taken up in this country with uncritical enthusiasm. If its value is confirmed it will be among the most valuable weapons we have for the control of tuberculosis, capable potentially of saving several thousand lives a year: though it can never replace the established methods of case-finding, isolation and treatment, nor diminish the importance of good housing and social conditions.

Guy's Diary

ACADEMIC

December		
		Exhibition. Surgical Department. "The Maintenance of Nutrition."
19th.	1.00.	Mr. Cook. Clinical Lecture. "Functional Uterine Hæmorrhage."
	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
22nd.	4.30.	X-ray Demonstration. Gordon Museum.
29th.	1.00.	Mr. Lawrie. Clinical Lecture.
	4.30.	X-ray Demonstration. Gordon Museum.
30th.	1.00.	Dr. Douthwaite. Clinical Lecture.
January		
		Exhibition. Surgical Department. "Pott's Disease."
2nd.	1.00.	Dr. Crisp. Clinical Lecture.
	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
	5.00.	Film Show. Department of Child Health. "Cross Infection in Maternity Units" Anatomy Theatre.

OTHER ENGAGEMENTS

December		
20th.	6.00.	Carols in the Wards. Southwark Cathedral Choir.
22nd.	2.30.	Salomon's Centre Party. Chapter House, St. Thomas Street.
24th.	2.30.	Landon Children's Tea Party, Out-patients' Department.
25th.		*On which day we wish you a Merry Christmas.*
29th.	8.00.	Maids' Dance. Nurses Home.
30th.	3.00.	Daily Womens' Party. Nuffield Sitting Room.
31st.		Rugby XV. *v.* Old Millhillians. (Headstone Lane).
		Association Football 2nd XI. *v.* Old Parkonians. (Away).
		Hockey 1st XI. *v.* Bank of England. (H.O.P.).
		Hockey 2nd XI. *v.* Bank of England. (Away).
		Hockey 3rd XI. *v.* Bank of England. (Away).
January		
1st.		*On which day we wish you a Happy and Prosperous New Year.*

Blood Discolouration of the Umbilicus

By O. JELLY, M.Ch., F.R.C.S.

THIS physical sign is commonly associated with the name of Cullen and quoted as indicating the presence of blood within the peritoneal cavity. My attention has been drawn to it on four recent occasions and it is interesting to compare the separate significance in these cases.

Case I. A rather stout middle-aged lady was seized with a sudden attack of upper abdominal pain which her practitioner considered was due to gallstones. Later the same evening he was doubtful because the pain had not abated and he suspected the presence of a leaking gastric ulcer. We agreed that pancreatitis was also a very likely possibility, and a grossly elevated reading of serum amylase confirmed this opinion. On the third day, Cullen's sign was evident and this patient recovered after a troublesome convalescence through paralytic ileus and pneumonia. No full scale laparotomy was ever performed but during the second week a small, right, subcostal exploration was carried out under local anæsthesia on the suspicion of a subphrenic abscess : some rather sticky, blood-stained exudate was drained from Morrison's pouch. On this occasion, Cullen's sign had been of real value.

Case II. A woman of 65 came to the Out-patient Department of Ancoats Hospital, complaining of abdominal pain and constipation. A mass could be felt in the left lower abdomen and there was blood discolouration of the umbilicus. She was demonstrated as a case of pelvic colon carcinoma and operative treatment was planned, the first stage to consist of a small right vertical laparotomy for exploration and preliminary transverse colostomy. No accurate explanation was given of the blood-stained umbilicus and neither abdominal distension nor ascites were obvious. A second ecchymosis over the external ring should have informed us that the origin of the blood lay in the abdominal wall and this may have changed our opinion on the mass itself. However, laparotomy was performed through a small right paramedian incision and the pelvic colon betrayed the feel and consistence of a thin lead pipe. Although the site of pathology, it was not the mass which had been felt and this lay in the parietes, diagnosed perhaps in convenience with the symptoms more than the clinical signs. Evidently this patient had strained and ruptured some fibres of the abdominal muscles. The colon lesion was a length of diverticulitis and transverse colostomy was completed to relieve her symptoms.

Case III. This elderly man underwent a successful prostatectomy some three months before being readmitted for progressive abdominal swelling. At first the doctor had suspected some return of urinary retention but clearly the swelling was due to ascites. A catheter entered the bladder without obstruction and withdrew only a small amount of highly concentrated urine. As well as the abdominal distension there was blood discolouration of the umbilicus. It seemed reasonable to expect that paracentesis would disclose a blood-stained peritoneal exudate but the fluid was straw-coloured and remained so after repeated tapping. There were distended veins around the umbilicus and the discolouration was no doubt due to rupture of one of these. This case was followed to autopsy after progressive deterioration and recurrent hæmatemesis. It remained uncertain whether the condition was due to cirrhosis of the liver or malignant peritonitis. This second alternative proved correct and the primary lay in the pyloric end of the stomach. The liver was not unduly large but contained secondary deposits.

Case IV. This elderly lady was admitted with acute abdominal pain and on examination the umbilicus displayed obvious ecchymosis. Moreover a mass could be felt occupying an area of the left rectus sheath. During the next few days the ecchymosis spread along the linea alba as far as the suprapubic area while her acute symptoms subsided. This patient had ruptured her left rectus muscle and no further investigation was carried out.

My memory of surgical text-books does not recall ecchymosis of the umbilicus to be a sign of ruptured rectus abdominis but this is clearly possible : similar staining is seen occasionally after a paramedian incision. The parietes must not be overlooked in the interpretation of Cullen's sign.

Guy's Hospital Clubs' Union

At the last meeting of the Clubs' Union Council a statement of the accounts for the year 1948–49 was received. A summary of this statement is given below :—

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR 1948–49

(to nearest £)

	£	£
To Ground Expenses :		
Wages of Groundsmen ..	694	
Rent of ground at Honor Oak Park	465	
Hire of other pitches.. ..	7	
Income Tax, Schedules "A" and "B"	87	
General Rates and Water Rate	229	
Miscellaneous Expenses ..	730	
		2,212
„ Expenses of Constituent Institutions :		
Association Football Club ..	96	
Athletic Club	49	
Boat Club	63	
Cricket Club	115	
Dental Society..	21	
Golf Club	26	
Hockey Club	49	
Ice Hockey Club	39	
Lawn Tennis Club	43	
Music Club	121	
Pavy Gymnasium	60	
Physical Society	3	
Rifle Club	55	
Rugby Football Club.. ..	382	
Sailing Club	35	
Squash Club	23	
Students' Club	804	
Students' Club (Table Tennis Club)	9	
Students' Union	10	
Swimming Club	1	
Theatre Club	22	
		2,026
„ Fares and Travelling Expenses :		
Association Football Club ..	24	
Cricket Club	41	
do. (Tour)	70	
Golf Club	3	
Hockey Club	28	
do. (Tour)	31	
Ice Hockey Club	12	
Rugby Football Club.. ..	296	
do. (Tour)	116	
Sailing Club	58	
Swimming Club	4	
		683
„ Other Expenses :		
Guy's Hospital Gazette (Staff)	66	
Guy's Hospital Gazette (Students)	226	
Maintenance of Squash Courts and Gymnasium	301	
University of London Athletic Union	67	
British Medical Students' Assoc.	1	
British Dental Students' Assoc.	23	
Office Salaries and Superannuation	200	
Pensions	112	
Printing and Stationery ..	23	
Audit Fee	16	
Insurances	90	
Sundry Expenses	69	
		1,194
	£6,115	

	£
By Subscriptions received during Year	4,585
„ Grant from Medical School ..	600
„ Grant from Dental School ..	300
„ Rents from Tenants	90
„ Net Gate and Stand Receipts ..	375
„ Interest on Reserve Fund	16
„ Interest on Bank Deposit	3
„ Donations	10
„ Balance being Excess of Expenditure over Income for the Year.. ..	136
	£6,115

From these figures it will be seen that over the twelve months concerned a working deficit of £136 was incurred.

For the current year 1949–50, budgets for the Constituent Institutions have been approved as follows :—

Association Football Club	£90	+ £22	Travelling Expenses
Athletic Club	£65	+ £20	,, ,,
Boat Club	£119		
Cricket Club	£90	+ £20	,, ,,
Debating Society	£5		
Dental Society	£37		
Hockey Club	£30		
Ice Hockey Club	£20	+ £15	,, ,,
Music Club	£35		
Pavy Gymnasium	£60		
Rifle Club	£51	+ £4	,, ,,
Rugby Football Club	£320	+ £365	,, ,,
Sailing Club	£18	+ £60	,, ,,
Squash Club	£37	+ £3	,, ,,
Students' Club	£850		
Students' Union	£10		
Swimming Club	£15	+ £10	,, ,,
Table Tennis Club	£10		
Tennis Club	£35	+ £10	,, ,,
Theatre Club	£15		

In order to avoid, so far as possible, any further deficit, the following resolutions were formally adopted :—

(i) No tours of athletic or sports teams be henceforth subsidised by the Clubs' Union Council.

(ii) With the exception of the Rugby Football Club First XV. no regular fixtures be made in future years outside the Greater London area without prior permission of the Finance Sub-Committee.

(iii) With the exception of the Rugby Football Club First XV. members of teams be not provided with shirts, shorts, or stockings at the expense of the Clubs' Union Council, but that the Council attempt to purchase such clothing on behalf of members in view of the present shortage.

Among other decisions reached at the same meeting of the Council was one for repairs and maintenance work to be undertaken at Honor Oak Park, the estimated cost to be as follows :—

Repairs	£647 5*s.* 0*d.*
Maintenance	£822 15*s.* 0*d.*

Included among the other matters considered at the same time were demolition of the air-raid shelters at Honor Oak Park ; the provision of books for a reference library in the new Club Room in the College ; the reduction of the stand charge at Honor Oak Park to one shilling for bona fide student members of the Clubs' Union, and the possibility of including advertisements in the programme of the Rugby Football Club.

Guy's Hospital Chapel

CHRISTMAS SERVICES, 1949.

Monday, December 19th.	9.15 p.m. Festival of Nine Lessons and Carols.
Friday, December 23rd.	9.30 p.m. Service in preparation for Christmas Communion.
Saturday, Christmas Eve.	11.30 p.m. Blessing of the Crib, Midnight Mass, Holy Communion with Carols.
Sunday, Christmas Day.	7 a.m. Holy Communion with carols.
Monday, December 26th. (St. Stephen, Martyr)	7 a.m. Holy Communion.
Tuesday, December 27th. (St. John, Apostle)	7 a.m. Holy Communion.

Holy Communion on Christmas Day also at—

Southwark Cathedral : 8, 9 and 11 a.m.
St. Hugh's, Crosby Row : 8 and 9 a.m.

W. DENYS GIDDEY, *Resident Chaplain.*

Reviews

A Twentieth Century Physician—being the Reminiscences of Sir Arthur Hurst, D.M., F.R.C.P. Arnold. *Price* 15*s.*

These are the reminiscences of a real person. For those like myself who knew Arthur Hurst well—and to know him well was to love him well, and to put him among the first—they are delightful reading, and for all they will be of absorbing interest. The great thing about this autobiography is that it shows him just as we knew him.

We remember him as a warm-hearted, generous, unselfish and loyal friend, and yet in some way a little difficult of approach. At home he was very happy, and throughout the book he pays a tribute of affection and gratitude to " Cooie " (Lady Hurst), who was his constant help and adviser and saved him from his own enthusiastic energy. His own family life meant much to him, and he often mentions appreciatively the happy family life he met among his colleagues on his travels. Of his friends he speaks rather in terms of their contribution to medicine or their success or their career than of their more personal graces or virtues, but this is misleading and gives a wrong picture of his relationship to others—he was a devoted husband and son, he spoke and thought kindly of all men and I very rarely heard him say anything unkind of anybody. In a genius of his calibre there was never occasion for jealousy. He was a great patron of the young, and often invited younger men to his home. But whether they knew him more intimately or only from his rounds in the ward, they regarded him with affection and with admiration—he was an inspired physician and an inspiring teacher.

Arthur Hurst with Osler stood pre-eminent among all physicians of all times for his international position in medicine—he seemed to be conversant with everything gastroenterological that was ever written anywhere and he seemed to know everybody of reputation or promise in Great Britain, France, Germany or America. In these he was helped by his amazing memory for facts and faces. In spite of his modesty he had self confidence, and these qualities enabled him to make friends in many languages, though the gods, among their many gifts to him, did not include the gift of tongues. He was not a hearty fellow who clapped people on the back, but he had a very real ability for making and keeping friends. He had a great sense of humour, which however somehow got lost somewhere in his enthusiasm. I have even seen him play the clown. Of his contribution to knowledge, his book gives us an illuminating account—he viewed medicine rather as clinician than a scientist—he was too subjective and too impatient ever to be a scientist of the first class, but he had imagination, and clarity of vision and a sense and appreciation of the practical, and with the help of these he contributed to gastroenterology and even to neurology, as much as any physician of his time.

In his reminiscences he mentions only once, in parenthesis, one of two physical disabilities which would have put most men completely out of the picture. As the years went on he became increasingly deaf. He brushed this disability aside and took no notice of it, though in truth he sometimes found a little deafness quite a convenience. And of his asthma, not a word.

Yes his book reveals him, a man of his family, kindly helpful, modest but self confident, courageous in his art, courageous in his physical disabilities, an international physician, and to all his friends and students an inspiration.

He was so very worth while, and the reminiscences of one so worth while are as stimulating as they are enjoyable. The reproductions of Herkomer's painting and Rothenstein's drawing fill in the picture so well that at the end you know Arthur Hurst.

Introduction to Clinical Surgery. By C. F. M. SAINT. 2nd Edn. H. K. Lewis. *Price* 45*s.*

This is a beautifully produced book which describes itself as " a reasoned explanation of surgical note taking." It embodies lectures given to surgical dressers. It is doubtful, however, whether surgical dressers at Guy's will benefit very much from reading in print what ordinarily they learn from honoraries and registrars at the bedside.

The book contains many excellent photographs but in our view photographs of gross surgical conditions such as these are of far less value than would be ones of smaller and more commonly occurring lesions. On the whole, this is a book worth reading for interest rather than for instruction.

Z.

Ankylosing Spondylitis. By F. HERNAMAN-JOHNSON and W. ALEXANDER LAW. Butterworth. *Price* 25*s.*

This book is divided into two parts: the first by Dr. Hernaman-Johnson on the diagnosis, medical treatment and general management of the patient with ankylosing spondylitis; the second by Mr. Alexander Law on the surgical treatment of ankylosed joints.

The first part commences with a good account of the typical clinical features of ankylosing spondylitis in a young man. The chief points in the clinical diagnosis and the early X-ray changes in the sacro-iliac joints are fully discussed. The chapter on radiological diagnosis is illustrated with excellent reproductions of X-ray films. Treatment is dealt with in a most comprehensive manner. X-ray therapy, both by the wide field method introduced by Dr. Gilbert Scott and by deep therapy, is discussed in detail. The final chapter in this section deals with the general management of the spondylitic and the affect of the disease on occupation, marriage, pregnancy, etc.

In the second part of the book, Mr. Alexander Law discusses the surgical treatment of the ankylosed joint. Osteotomy of the spine to correct flexion deformity, and the Smith-Peterson cup arthroplasty procedure for the hip, are fully described. The photographs showing the various stages of the operations have reproduced poorly, and are of little practical value. The pseudarthrosis procedures for the hip, which many orthopædic surgeons regard as simple procedures of great value for ankylosing spondylitis, are dismissed in a few lines. The final chapter deals with the treatment of ankylosis of the temporo-mandibular, shoulder, elbow, knee and ankle joints, and of the joints of the foot.

Dr. Hernaman-Johnson's claim to have produced a practical guide to the diagnosis and treatment of ankylosing spondylitis is fully justified. This little volume, particularly the chapters on clinical and radiological diagnosis and X-ray treatment, should prove of real value to the student and practitioner.

J.S.B.

Fractures and Dislocations in General Practice. By JOHN HOSFORD. Revised by W. D. COLTART. 2nd Edn. Lewis. *Price* £1 1*s.*

Despite its title, it would not be surprising if more copies of this volume were sold to medical students than to general practitioners. Originally written in 1939 by Hosford of Bart's (and now revised by a colleague), it provides a concise yet easily digested and well-illustrated account of the common fractures and of the principles underlying their treatment. More stimulating than the relevant chapters in one of the standard surgical text books, it nevertheless confines itself strictly to the "common things that commonly occur." The influence of Watson-Jones is freely acknowledged; and if, by comparison, the vigour and eloquence of his style is lacking, that is perhaps inevitable in a book of this size. An attractive feature is an appendix in which brief reference is made to the lives of Pott, Colles, Bennett, and others, a nodding acquaintance with whom should not only interest the reader, but may also help to please his examiner.

T.B.

Textbook of Bacteriology. By R. W. FAIRBROTHER. 6th Edn. Heinemann. *Price* £1.

The latest edition of this well-known book gives a clearly expressed account of the medical aspects of bacteriology. The sections on antibiotics and viruses have been brought up-to-date and there is a short note on the Rh. factor. The application of bacteriology to clinical medicine is adequately stressed. Most of the contents make interesting reading but for a book primarily intended for the medical student there is still far too much detail especially in the part dealing with systematic bacteriology.

E.A.W.

Fitness for Games. By F. A. HORNIBROOK. Heinemann. *Price* 2*s.* 6*d.*

This little booklet begins with some useful practical tips on training for the weekend games player. The need for restraining the youngster in his teens is stressed, for many prominent schoolboy athletes take their training much too seriously, and are "burnt out" before they reach manhood. There is some sensible advice on various medical conditions such as hernia, varicose veins, back strains, sprains, etc.; on the use of tobacco and alcohol, and also on the care of equipment.

Although this booklet is unlikely to make any appeal to the medical student, it should prove useful to young men who indulge in week-end sports.

J.S.B.

Correspondence

The Clubs' Union

SIR,—Before the war the *Gazette* published the Clubs' Union balance sheet, but owing to the paper shortage this practice could not be continued.

A few weeks ago the *Gazette* invited the Clubs' Union Council to resume the practice of submitting an annual balance sheet for publication, and the preparation of this was immediately started by the Council, and the *Gazette* informed accordingly. This has taken a little time to produce and is published in the current issue of the *Gazette*.

With regard to the economies required, the club secretaries have been fully informed of the decisions reached by the Council in the customary manner. The relevant decisions are also published in the *Gazette*.

I trust that Mr. Dobson-Smyth will now have sufficient information on this subject.

Yours, etc.,

P. G. LARGE,
Honorary Secretary, Clubs' Union.

Medical School,
Guy's Hospital, S.E.1.

The Medical Curriculum

SIR,—With reference to Passim of December 3rd, none would disagree with your plea for the wider education of medical students. I would, however, suggest that pruning the courses you mention will in no way contribute to this end.

As to botany, it seems to me that medicine is best considered as a branch of biology. After the first year there is little mention of botany and many students make their sole contact with botany during the first year. Plants are most important living organisms, indeed. Animal life, as we know it, is dependent upon plant life. The botany course is already short enough and I plead that it is not made shorter.

Chemistry is of growing importance in medicine. Some students do chemistry for the first time during the first M.B. course. Later they study organic and bio-chemistry, the latter concerned with processes fundamental to the living state of matter. We should not deprive the student of an opportunity to grasp the elements of a subject which may later give him flashes of more profound and gratifying insight into some of the more beautiful aspects of living organisms.

Anatomy deals with the human body, which will be of life-long interest to most students of medicine. If your plea for reduction refers to the elimination of dead, dry-bone and dusty academic anatomy, I would agree. But I do not recall that such was taught at Guy's. Functional, dynamic, living anatomy was always stressed. Dissection seems to me to be of great importance, and it is certainly no disadvantage to a student to have examined at least one human body in moderate detail.

The question of special investigations during the clinical years calls for special mention. It is obviously of great importance that a student should strive to master physical examination. Why not give some time to special investigations as well? My experience as assistant clinical pathologist at Guy's convinced me that a surprising degree of ignorance of the meaning of even simple investigations may often be encountered. Students should know when to ask for the various routine investigations, and should be aware of the limitations of investigations too. Only thus can haphazard, over-credulous and over-sceptical attitudes be avoided.

It may be that some subjects can be rearranged, but it seems that those you mention are already presented in minimal detail. Students should be interested in anything to which they can turn hand, eyes, ears and nose. If they maintain an attitude of general interest after as well as before qualification, do not become slaves to pernicious little lists, and are prepared to give a little extra time to fundamental subjects such as biology and bio-chemistry, there will be little danger of the lack of general education which you fear.

Yours, etc.,

FRANCIS L. JACKSON.

Lister Institute,
Chelsea Bridge Road.

The Annual Hockey Dinner

SIR,—The annual hockey dinner was held on November 24th, and a most pleasantly informal affair it was, too. During the war years this excellent custom fell into abeyance, but since its revival the whole conception has been broadened so that now not only are all ex-members of the club welcome, but it is proposed to precede the dinner by a Past *v.* Present match to be played, of course, at H.O.P.

This year the thin edge of the wedge, albeit a blunt one, was provided by three ex-members of the club who, abetted if not aided by the first eleven forwards, were convincingly defeated by the first eleven defence and a scratch forward line. Next year, however, we hope to have our revenge, and to further this end I am already on the look-out for potential players. If any ex-member of the club who is prepared to play next year will contact me direct, or via The Gazette Office, I will send him two reminders, one six weeks and the other one week before the match. This should give adequate warning and enable us to field a reasonably strong side.

In conclusion, I would like to congratulate the Captain and Secretary of the Hockey Club for their initiative in organising this year's match.

Yours, etc.,

Stokenchurch, R. A. KEABLE-ELLIOTT.
High Wycombe, Bucks.

Obituary

ERNEST WILLIAM GIESEN.

BORN in Wellington, New Zealand, Ernest William Giesen passed the whole of his professional life in that city, apart from the five years during which he trained at Guy's. Practising first as a pharmacist, he took up medicine comparatively late in life and qualified M.B., B.S. London in 1905. Back in his own country he achieved prominence both as a consulting physician and as a teacher. To a phenomenal knowledge of pharmacology and therapeutics he added a wide experience of men and affairs and a special interest in the medico-legal field.

In his later years he retired to his home at Lower Hutt where he ultimately died—a Guy's man who will be remembered as a great doctor and one who showed a deep understanding of his fellow men.

H. D. WYATT.

MANY old Guy's men will learn with regret of the recent death in the Hospital of Dr. H. D. Wyatt. During his student years he played a large part in the social life of the Hospital. He was probably the best all-round cricketer that Guy's ever had. His outstanding performance was a faultless innings of 173 not out against Bart's in the most important inter-hospital match of the season. It was then the highest score but one ever made in inter-hospital cricket. Whilst still a student he played for Middlesex under the captaincy of Sir Pelham Warner. After his first match for the County, one of the evening papers devoted considerable space to his fielding, suggesting that some other members of the team would do well to copy his example. He was also a very useful change bowler and was a general favourite with all who associated with him.

Wyatt's skill at lacrosse was on a par with that of his other sports. I am under the impression that he played for the South *v.* the North. Had he taken his lawn tennis seriously, he would have been up to Wimbledon standards.

Wyatt had a pleasing tenor voice and took a leading part in hospital concerts, and particularly in those in the wards at Christmas.

At the time of his death he was on the staff of the Ministry of Pensions where he had worked for over 30 years.

B.H.S.

P. DILES.

THE death is announced of Mr. P. Diles whom Guy's men since 1935 will no doubt remember as one of the College porters. He came to the Hospital after a varied career, including four years' service in the 1914-18 War when he enlisted at the age of sixteen. Unfortunately he suffered considerably with illness, a fact which necessitated his early retirement. Nevertheless, he was later re-employed as a porter at the York Clinic where he was at work until a short time before his death in October.

To his widow, every sympathy is extended.

Sport

RUGBY FOOTBALL

Guy's *v.* Coventry

At H.O.P. Won 10—6.
3rd December, 1949.

Guy's *v.* Old Cranleighans

Away. Won 22—3.
10th December, 1949.

Guy's reached their best form in the last two games when they beat Coventry and the Old Cranleighans. The Coventry side was weakened by having five players at the first international trial, but nevertheless, the side that represented them was worthy of the club.

The game was played in fairly wet conditions and with a stiff breeze blowing down the pitch. Guy's played against the wind to start with and had to defend early on. D. Graham scored an unconverted try for Coventry after some clever work. Guy's then settled down and played some good football. The ball was trown about and the backs and forwards combined well together. These movements nearly produced two tries, both Williams and Rademan being unlucky. So the score stood at half-time.

The second half produced tremendous excitement. The game fluctuated from end to end and then A. Large started a movement from a line-out which ended in a try by Pook. Davies converted. Both sides nearly scored again and then Coventry wrested the advantage with a penalty goal by F. Walton. The game went on fast and furious and excitement rose to fever pitch when Rademan emerged from a loose ruck with the ball firmly clasped under one arm and hurled himself over the line. Davies converted.

The game against the Old Cranleighans brought forth some lovely football from both sides. The Old Boys went ahead through a penalty goal. This was equalised quite quickly with a penalty goal by Davies. Then Birch scored in the corner and Davies converted. In the second half Guy's had matters much their own way. Birch, Wilson, and Howells scored tries and Davies converted one and kicked another penalty goal.

Both games showed Guy's in an aggressive mood playing attacking football. It is most encouraging after the indifferent start to the season.

Team v. Coventry : J. F. Pritchard, B. M. Gray, E. S. P. Williams, W. J. Howells, W. Birch, J. F. le Clus, A. Large ; C. T. M. Wilson, J. Robinson, J. Kirkbride ; C. Pook, S. F. Knipe ; T. G. Bellis, W. A. Davies, P. Rademan.

Against Old Cranleighans : F. Heber played instead of Williams.

HOCKEY

Results December 3rd, 1949.

Guy's I. *v.* Sittingbourne. Won 4—2.

Guy's II. *v.* Hays Wharf. Won 4—1.

Guy's III. *v.* Oxted. Lost 0—5.

Guy's IV. *v.* Nat. Phys. Lab. IV. Draw 2—2.

Guy's I. *v.* Metropolitan Police

At H.O.P. Won 4—2.
10th December, 1949.

On a fast pitch the Police took the advantage during the opening stages of the game. Guy's were kept on the defensive, the forwards only breaking away occasionally. Guy's defence soon settled down and the game moved into the Police half. The Police goalkeeper was mainly responsible for the score being 0—0 at half-time. The play was fast after half-time and it looked like being a goalless match. When Opie got a crack on the right hand he was all but out of the game for a few minutes, then to show he had recovered, he scored Guy's first goal. A few minutes later, taking a rebound from the goalkeeper's pads, Opie again scored. The game then seemed to develop into a series of corners until the Police centre-forward scored with a nice run through. Earl, for Guy's, tried the same tactics to score Guy's third goal, and a few minutes later by taking a first-time shot scored a beautiful goal. In the failing lght the Police rallied and were rewarded by a fine goal from their inside right to reduce Guy's lead to two goals.

Team : F. H. Walker ; G. H. Danford, H. Carter ; C. F. M. Robinson, E. A. Murray, R. Sandfield ; D. V. Duckworth, D. E. Blake, S. Earl C. H. Opie, R. Hodson.

MEDICINE BALL

Tankards *v.* Old Masonians

Result—Won 37—0.

It is not easy for æsthetes to find places in Rugby teams—they have a rotten habit of screaming in the scrum and lack the ability to convert the easy tackle into the miraculous near miss.

However, since the Tankards' aim is to drink hard and not to bother about the Rugby, the æsthetes qualify by pallidly smoking unlighted pipes, hoping that tweedy jackets will disguise slender limbs and pretending through the long and tedious drinking hours that their glasses have just been filled.

So on Saturday they met and shyly changed (taking off their shirts last) and, giggling shrilly, ran onto the field.

Their garb was tasteful. The fair wore pastel shades while the dark and exotic dressed in crimson, rich purple and bottle-green, the overall effect being similar to Frith's "Derby Day", only winter and not so many people.

The game commenced and it was at once apparent that Guy's were to have a comfortable win since the opposing side were a soccer team and though eleven men would have been ample, the fact that the goalkeeper was the only one who could handle the ball (and his runs, though brilliant, were of necessity brief since he could not pass out of the penalty area) proved an insurmountable obstacle.

Also his attempts to save converts (which he imagined to be penalties) severely taxed his strength.

So the Tankards ran superbly through the opposite side whose defence, consisting as it did of sliding tackles and shoulder charging, proved weak. Also they had a monopoly of the line-outs as the opponents' efforts to head the ball back was not entirely adequate.

It was an excellent example of the superiority of Rugger players to Soccer players, and loud was the high-pitched clamour of the Tankards over their hated beer.

"—and Murray Hofmeyr agreed."

"—as I said to Nelles Vintcent."

ASSOCIATION FOOTBALL

LONDON UNIVERSITY CUP

Guy's *v.* University College

Away. Lost 1—3.
23rd November, 1949.

This performance of the Guy's XI. was, as yet, their worst this season. The side never settled down and although on one occasion they appeared to have almost saved the situation, a further defensive error put our opponents two goals ahead at such a late stage in the game as to be almost unassailable.

From the first minutes the University College forwards attacked strongly, and a series of mistakes by a normally sound defence found them out of position and the home side netted the ball. For the remainder of this half play was very scrappy, the Guy's wing-halves and full-backs failing to open out the play by long across-the-field passes.

The second half began as the first, and Guy's were soon two goals down. A foul against Harris resulted in a penalty, the ensuing goal being the only one scored by Guy's, who were at that time just one goal down. For a long period Guy's tried hard to level the scores, but a breakaway by the University College centre-forward resulted in the final goal of the match, sealing the fate of the visitors, for they never fully recovered. Thus the final whistle blew with the Guy's XI. two goals down, and eliminated from the London University Cup in the first round.

We wish our opponents, University College, the very best of luck for the following rounds.

Team : A. Fearn; D. Lipington, M. Bishop; D. Mathews, D. Allen, A. Swift; B. Cornhill, C. Leckie, D. Harris, A. Prince, E. Sturdy.

Guy's *v.* London Welsh

At H.O.P. Won 1—0.
3rd December, 1949.

As a result of our elimination from the London University Cup, we had no fixture for this day. It was decided to arrange a friendly game (as opposed to league) thus enabling the Hospital to rest some of the 1st team members.

Our opponents were to be the London Welsh with whom we already had some connection in the form of Sturdy.

From the start we pressed hard, having won the toss and taken advantage of the gusty wind. The Hospital appeared on top in these opening stages, and many early chances in front of the goal were missed. Newton worked the ball well in front of the goal, only to push his final shot over the bar. Meanwhile the Guy's defence had not had everything their own way, and on several occasions Fearn, in goal, pulled off some really fine saves.

The Hospital goal came late in the first half. Newton worked his way out to the right wing and centred along the ground. Cornhill, who had moved inside, ran up to the ball, then over it, letting it run on to Leckie, whose resulting shot gave the London Welsh custodian little chance.

The teams changed over with no further increase in the score. The London Welsh having this half the advantage of what appeared an increasingly strong wind, set their forwards moving frequently. But the Hospital defence held and we ran off the victors, if a little luckily, by the only goal scored.

The Hospital half-back line, Rice, Southgate and Wilcocks, all from the 2nd XI., played well but would improve if the wing-halves payed a little more attention to their distribution of the ball to their forwards.

Team : A. Fearn; D. M. Lipington, J. Wylie; V. Rice, P. Southgate, G. Wilcocks; B. Cornhill, E. Newton, C. Leckie, D. Oldfield, E. Sturdy.

A.F.A. SENIOR CUP—FIRST ROUND

Guy's *v.* Old Brentwoods

At Brentwood. Lost 2—6.
10th December, 1949.

Guy's travelled to Brentwood to play the Old Boys full of hopes for progressing further in the Cup. However, when the final whistle blew these hopes were buried beneath a veritable stock of goals.

Guy's were forced to take the field without Sturdy and with Matthews in doubtful condition, both having been injured the previous Wednesday when playing in a United Hospitals' match.

The first-half play was very even indeed and there was much end-to-end play. During this period the Old Boys were a little fortunate to score two goals but the Hospital replied with an excellent effort by Leckie whose finishing cross shot left the goalkeeper helpless.

The beginning of the second half was a very different tale, and within twenty minutes the Old Boys added four further goals which put the final result beyond doubt.

Despite this defeat, however, the Hospital side played hard football and for a period were on top. They were rewarded with an excellent goal when Swift, with his head, converted a pass from Bishop to positive effect.

It was obvious that Fearn's ankle was giving him trouble throughout the game, and consequently his kicking was affected and this was one reason for the extreme wings being neglected.

Guy's crop of injuries, however, in no way detracted from the excellence of the Old Boys' win, which they fully deserved. They played as a team whose hearts were in the game and were justly rewarded.

The Hospital side was as follows :—

Team : A. Fearn; D. Lipington, M. Bishop; D. Matthews, D. Allen, A. Prince; B. Cornhill, E. Newton, D. Harris, C. Leckie, A. Swift.

SQUASH

At the end of the first half of the season the Hospital have played thirteen matches, winning six and losing seven. Taking into consideration the strength of the teams played, this is a satisfactory result and an improvement on last season.

We have also reached the semi-final of the Hospitals' Cup, having defeated King's College Hospital by five matches to nil. We now meet St. Mary's in the New Year.

The following have represented the Hospital First Team :—

D. R. Pugh, P. L. Pickett, L. Jacobs, C. J. G. Menzies, D. E. Blake, M. A. C. Lyon.

The second team has played five matches, winning three and losing two.

P.L.P.

Note.—Students are reminded that they must not book courts more than three days in advance. They are liable to have their court cancelled if they do.

A REMINDER

The attention of contributors is drawn, to the fact that anonymous articles cannot be accepted. An author's name can be withheld from publication if specially requested.

Hospital Information, etc.

NOTICES

APPOINTMENTS VACANT

GUY'S HOSPITAL DENTAL SCHOOL

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School for a **Scholarship** tenable for one year at the **Northwestern University, Chicago,** commencing in September, 1950. The Scholarship covers the cost of tuition fees and at the end of the course the holder will be eligible for the D.D.S. degree.

Forms of application may be obtained from the Dean, Medical School Office, Guy's Hospital, S.E.1. Closing date for applications is Tuesday, 31st January, 1950.

Applications are invited from graduates in Dental Surgery trained at Guy's Hospital Dental School for the **Dental Travelling Scholarship.** The Scholarship will enable the holder to pursue a course at one or more Colonial or Foreign Dental Schools. The Scholar will normally be required to proceed abroad at such time as will enable him to commence the course in October, 1950.

Forms of application may be obtained from the Dean, Medical School Office, Guy's Hospital, S.E.1. Closing date for applications is Tuesday, 31st January, 1950.

GUY'S HOSPITAL MEDICAL SCHOOL

Applications are invited for the appointment of **Lecturer** in the **Pharmacology Department.** The appointment will date from as soon as possible after 1st January, 1950, and will be for two years in the first instance. Salary £800 × £100 to £1,100, plus superannuation and family allowance. The initial salary may be fixed above the minimum of the scale according to the experience and qualifications of the candidate selected.

Forms of application obtainable from the Dean, and should be lodged in the Medical School Office not later than 30th December, 1949.

Applications are invited for the appointment of **Junior Assistant (Research) to the Director of the Department of Surgery.** Appointment will date until 30th September, 1949, in the first instance, at a salary of £550 per annum, plus superannuation and family allowance.

Forms of application are obtainable from the Dean, Guy's Hospital Medical School, S.E.1, and should be forwarded to him together with the names of three referees not later than 20th December, 1949.

GUY'S HOSPITAL, S.E.1.

Applications are invited for the appointment of three **Junior Medical Registrars** commencing in the New Year. Salary £670 per annum. Appointment until 30th September, 1950, in the first instance. Forms of application and copies of Standing Orders for the appointment may be obtained from the Dean, Guy's Hospital Medical School, and should be forwarded to him not later than 27th December, 1949.

SCIENTIFIC FILMS

The Society of Cultural Relations with the U.S.S.R. has arranged to show two films in connection with the Pavlov Centenary Celebrations. The first "Mechanism of the Brain" will be shown on Monday, November 28th, at 5 p.m., at the Anatomy Theatre, Guy's Hospital. Admission by series ticket already issued or by ticket (2*s.* 6*d.*) on application to the Society at 14, Kensington Square, London, W.8.

THE SIR ALFRED FRIPP MEMORIAL FELLOWSHIP IN CHILD PSYCHOLOGY

Applications are invited for **The Sir Alfred Fripp Memorial Fellowship in Child Psychology** from medical graduates, men or women, under the age of 35, preferably with experience in Pædiatrics as well as in Psychological Medicine. Stipend £150 a year. This appointment is for two years and may be held concurrently with a part-time appointment elsewhere. Applications should be forwarded to the Dean (from whom copies of the regulations may be obtained), together with the names of three referees. Applicants should submit a definite scheme of advanced study or research work to be carried out during the tenure of the Fellowship together with particulars of their previous career. Applications should be forwarded by 5th January, 1950.

GUY'S HOSPITAL DENTAL SOCIETY

The 44th Annual Dinner of the Dental Society will be held at the Park Lane Hotel, Piccadilly, W.1, on Saturday, 4th March, 1950. As in past years a Clinical Meeting will be held in the Dental Department on the same day.

Further particulars will be given later.

PAPERS BY GUY'S MEN

Blumenthal, C. J. Corneal graft in a European eye. Using a non-European transplant. *South African Med. J.*, 1949 (Oct. 8th).

Braithwaite, F., Channell, G. D., Moore, F. T., and Whillis, J. The Anatomy and Function of the Extensor Complex. *J. Plastic Surg.*, 1949, **2**, 175.

CHANGES OF ADDRESS

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J. D. Whitehouse, M.R.C.S., L.R.C.P., 94, Beaconsfield Road, Brighton, 6.

BIRTHS

REES.—On December 16th, 1949, at High Barnet, Hertfordshire, to Kathleen (née Harris), wife of Dr. R. Rees—a daughter (Diana).

SALMON.—On December 3rd, 1949, at Guy's Hospital, to Maude (Pip) (née King), and L. F. W. Salmon—a brother (Richard Christopher) for Elizabeth Ann.

MARRIAGES

EADES—SYKES.—On November 12th, 1949, at Mill Hill, N.W.7, John B. Eades, Capt. R.A.M.C., to Ann Sykes, S.R.N.

DEATHS

COOPER.—Charles Edward Cooper, B.A., M.B., B.Ch., of Stoneleigh, Salcombe, S. Devon. aged 81 years.

GIESEN.—Ernest Tom Giesen, M.B., B.S., M.R.C.S., L.R.C.P., of Lower Hutt, Wellington, New Zealand.

MARAIS.—Christopher Albertus Marais, L.M.S.S.A., L.D.S., R.C.S. (suddenly), of Geneva House, Cape Town, S. Africa.

TRETHOWAN.—On December 1st, 1949, Joan Durham Trethowan, M.R.C.S., L.R.C.P., of Manabeer House, Yelverton, S. Devon.

WYATT.—On 24th November, 1949, Harold Douglas Wyatt, M.R.C.S., L.R.C.P., of 651, Chelsea Cloisters, S.W.3.

EDS. {R.G. P.A.Z.

GUY'S HOSPITAL GAZETTE

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PASSIM

A Happy New Year to all our readers ! We should like to add " and a prosperous one, too ! The word, however, is démodé, it is almost archaic and, truth to tell, looking round the Hospital at Christmas time it seemed to us that people can be surprisingly happy without being particularly prosperous. Therefore, a Happy New Year to you !

London, whether at Christmas, New Year, in spring or autumn, has always seemed to us to be the greatest city we have ever known. Neither Athens, nor Rome, nor New York, nor any city from the east of Europe to the west of America holds for us so much interest or so much fascination as London. Indeed, we sometimes think that of the things for which Thomas Guy is given credit he has never been given enough praise for founding Guy's in London. He might have founded it elsewhere. It might, if he had done so, still have gained a great reputation. Its name might still have been mentioned with affection and respect across half the world. Yet we feel that no little of its eminence is due to its having been set in London. It grew up in London. It made its contribution during the advance of this great city from eminence to pre-eminence. It developed as London developed. It shared in London's triumphs. More recently it shared its troubles. It was and is one small but still important corner of London. So are the other London Hospitals ; and each reflects something of its locality : St. Thomas' its quiet Thames side site and its view across to the Houses of Parliament ; Bart's, the oldest of the London Hospitals, its busy market environs and its ancient churches ; Guy's, the Borough and its nearby slums, the Thames and its wharfs and London Bridge Station with its constant, bustling, teeming passenger population. And yet all three Hospitals from their special place in the great city, all three derive much good from influences beyond these local scenes. A student at Guy's like other London students has surrounding him the whole wealth of a great city—all its colour, its life, the richness of its art, its literature, its music, its entertainment, its people of every sort and the natural beauty and elegance of its Parks. They surround him, they are there for his enjoyment and his small means are a restriction on but not a barrier to their enjoyment. Yet we doubt whether to many students it all means very much. Last week, on a day of glorious December sunshine, when the Tower, St. Paul's, the Parks, the River were glistening like some enchanting scene from a storybook we overheard two students, bored, arranging to go to " the flics " " for want of something better to do."

We shall not labour the point but just remind our readers that they who are lucky enough to be at Guy's are also lucky to be in London and that London holds a variety of sights and scenes probably to be unequalled in their lives—the River by night, the morning sunshine in St. James' Park, the Round Pond at sunset, the flowers at Kew, the markets, the churches, the pubs, the people. All these provide a background to a student's days which forever after should make him glad—or sorry—depending upon whether he enjoyed them or " for want of something better to do " went to " the flics."

WE deeply regret to record the death on December 17th of Mr. Lancelot Bromley, M.Ch., F.R.C.S.

Mr. Bromley was at Guy's as a student and afterwards as Surgeon, Warden of the College and Dean of the Medical School. We offer our deep sympathy to his wife and family.

JUST before Christmas, an employee of the Hospital had a considerable loss. We have been asked to thank those many kind people, who, having heard of it, helped without being asked, some anonymously, to make it good.

Obituary

LANCELOT BROMLEY, M.Ch., F.R.C.S.

THE sudden death of Lancelot Bromley on 17th December, at the age of 64, came as a great shock to his many friends, who had always regarded him as unusually fit and well. At all times will he be remembered at Guy's, not only for his services to the Hospital as Surgeon, Warden of the College and Dean of the Medical School, but also for his unassuming and friendly character—his presence on every occasion, in operating theatre or ward, inspiring those around him with confidence and optimism.

He was educated at St. Paul's School and Caius College, Cambridge, before he came to Guy's in 1906. By then he had taken the B.A. degree with Honours and played golf for the University. He qualified in 1909 and took the F.R.C.S. in 1912 and the M.Ch., Cambridge, in 1913. At Guy's he was House Surgeon to Sir Alfred Fripp and became Surgical Registrar in 1911. He was Warden of the College from 1912 to 1919, one of the few Wardens to live with their family in the College. In 1916 he was appointed Assistant Surgeon to the Hospital and in the same year joined the R.A.M.C., to serve in Salonica and Italy until 1918. He was elected Dean of the Medical School in 1915, which office he held until 1920. His appointment as Surgeon to Surbiton and Putney Hospitals in addition to Guy's meant a large and busy hospital and private practice, which he kept up until his retirement to Seaford in 1946. During the late war he devoted a large proportion of his time to work on Service personnel at the Ministry of Pensions Hospital, Stoke Mandeville, and resigned from the staff at Guy's in 1942 in order to continue his work there.

More of a clinician than a scholar he wrote little but was an excellent teacher in the wards and, in the theatre, a superb craftsman who stressed the need for gentleness in the handling of living tissues. For twenty years he was examiner in Surgery in the University of Cambridge.

No biography of Lancelot Bromley would be complete without mention of the important part played in his life by his family, and in particular by his wife, Dora Bromley, sister of the late Harry Lee, the Leeds' Ophthalmic Surgeon, also a Guy's man. For it was in the bosom of his family that he spent all his spare time and was able to indulge with them in his love of sport—golf, racing, yachting and ski-ing. He had a daughter who married Dr. R. A. P. Hogbin, formerly a Guy's Rugger Captain, and two sons ; John, the elder, a glider pilot, was killed on D. Day near Caen ; Lance, the younger, is also a surgeon, now training in thoracic surgery. To Mrs. Bromley and her daughter and son we extend our deepest sympathy in their great loss.

T.L.

Correspondence

Passim

SIR,—I feel that the attitude of Passim (December 17th) on the subject of Christmas should not pass entirely unchallenged. While welcoming the timely reminder that the true message of Christmas must not be fotgotten, and the exhortation to heart searching on the part of everyone at this season, it would seem to me that the writer has failed to carry out his own precepts to any great extent.

In addition to being a festive season and " an important economic event," Christmas is fundamentally the time at which is remembered God's gift of His Son, Jesus Christ, to be the Saviour of the world, so that it is more even than the festival of The Child. The historicity of the events celebrated has not been disproved, or even seriously challenged, by those sceptics, however eminent, who are searching for a creed. These miraculous events then are surely worthy of the consideration of all.

It is to be hoped that your readers, the patients of this Hospital, and, indeed, all men and women everywhere, will have paused in their festivities this Christmas to consider these things, and their own individual responsibility toward this gift of God. Perhaps many will feel with me that we ought to join with the " multitude of the heavenly host, praising God, and saying : Glory to God in the highest, and on earth, peace among men in whom He is well pleased." (St. Luke, ch. 2, verses 13–14, R.V.).

Yours, etc.,

ROBIN J. CATLIN.

Chairman, Guy's Hospital Christian Union.

"Diseases of Adaptation"

By P. M. F. BISHOP, D.M.

A Clinical Lecture delivered at Guy's Hospital Medical School on Tuesday, November 29th, 1949.

"Adaptation to our surroundings is one of the most important physiological reactions of life. One may even go so far as to say that the capacity of adjustment to external stimuli is the most characteristic feature of living matter."—Selye.

INTRODUCTION.

THE more one sees of the functions of the endocrine system the more one is impressed by the fact that the endocrine glands are mainly concerned with adjusting the organism to changes in the external environment, and consequently, that endocrinology and metabolism are so intimately associated that it is difficult to define where one begins and the other ends.

Indeed it has now become essential for the investigation of modern endocrine or metabolic problems to set aside from the rest of the routine of the hospital a metabolic ward where proper studies can be made of these disorders which are assuming increasing importance in the general structure of modern medicine.

Such metabolic wards are already established in a number of the teaching hospitals, and it is likely that Guy's in due course may also establish a similar unit.

The subject of this lecture is a series of disorders collectively known as diseases of adaptation. The work which has led to the identification of these diseases has for the past 15 years been conducted very patiently and with infinite care by Hans Selye, of Montreal, mainly on experimental animals. Recent developments have emphasised its importance in clinical medicine, and I feel that it is of such topical interest that I should like to draw your attention to it at the present time.

"SHOCK."

For many years surgeons, physicians, obstetricians, and others have recognised a syndrome which for want of a better name they have called "shock." It may be known as traumatic shock or post-operative shock, or obstetric shock, or the shock resulting from burns, or anaphylactic shock following administration of certain drugs. During the war a special type of delayed shock was identified, occurring in people subjected to severe crushing injuries, from collapse of buildings during aerial bombardment. This "crush syndrome" was associated with renal failure.

The classical symptoms are a lowered temperature, a lowered blood-pressure, diminished blood volume, increased capillary permeability, depression of the nervous system, with fainting or unconsciousness, lowered blood sodium and chlorides, raised blood potassium, and sometimes gastro-intestinal ulcers.

It is obvious that all sorts of different forms of stress may give rise to shock, but it is perhaps not sufficiently realised that the degree of shock may vary from a condition so mild that it could only be recognised perhaps by tachycardia, transient hyperglycæmia or leucocytosis, or it may be so severe as to cause immediate death. The similarity between shock and the crisis of Addison's disease has been noted, and it was suggested at one time that a clinical trial of cortical hormones in the treatment of shock might be made. I can remember at the beginning of the war earnest deliberations as to whether it would be wise to procure large stocks of deoxycorticosterone acetate for this purpose. The association between shock and status thymico-lymphaticus has also been observed, and often at post-mortem on patients who had died of shock a large thymus was the only pathological finding.

THE GENERAL ADAPTATION SYNDROME.

Selye's contribution to this problem was to link the various forms of shock together and to study the changes which occurred following the shock phase. He has described these changes under the title of the "general adaptation syndrome." It consists of three main stages.

"*The Alarm*" *Reaction.*—The first is the "alarm" reaction, and comprises two phases, "shock" and "counter-shock." Any non-specific stimulus which can give rise to shock is known as an "alarming" stimulus. Not only does it produce shock

but it also stimulates the anterior pituitary to secrete an excess of the adreno-corticotrophic hormone (A.C.T.H.), at the expense of the secretion of other anterior pituitary hormones, such as the growth hormone, the gonadotrophic hormones and the lactogenic hormone. This excessive production of A.C.T.H. stimulates the adrenal cortex to secrete an excess of its various hormones.

The " alarming " stimulus therefore has affected the anterior lobe of the pituitary in such a way that there has been a " shift in pituitary hormone production " in the direction of A.C.T.H. and away from the gonadotrophic hormones, the growth hormone, and the lactogenic hormone, and the final result is stimulation of the adrenal cortex.

The Adrenal Cortical Hormones.—There are three groups of adrenal cortical hormones. There are the "*sex hormones*" represented by œstrogen, progesterone, and a number of weak androgens which are excreted in the urine in the form of neutral 17-ketosteroids. The second group consists of the "*salt-and-water hormones*," exemplified by the synthetic compound deoxycorticosterone. They are responsible for the control of the metabolism of sodium, of chlorides, of potassium, and of water. Over-action of these hormones gives rise to hypertension and œdema, and may lead to severe pulmonary œdema, causing death, as sometimes occurs in Addison's disease when deoxycorticosterone acetate is given in excessive doses. The third group of hormones are the "*sugar hormones*" and are exemplified by corticosterone and by 17-hydroxy–11-dehydrocorticosterone (" cortisone " or " compound E " of Kendall). These sugar hormones are responsible for increasing the glycogen stores, if necessary by converting protein from the tissues, mainly from the skin, the peripheral vessels, and the matrix of the bone into sugar, which is laid down in the liver in the form of glycogen. To some extent the sugar hormones and the androgens are antagonistic, because over-activity of the androgenic hormones gives rise to a positive nitrogen balance and to the laying down of protein in the skin, the peripheral vessels, and the matrix of the bone. Indeed, apart from their androgenic properties these hormones also have a nitrogen-retaining action or " protein-anabolic " effect, which is made use of with considerable benefit in certain conditions in which there is a considerable degree of protein deficiency, such as Simmonds's disease and Addison's disease. This interaction between the nitrogen-retaining hormones and the sugar hormones provides an example of a " shift in adrenal cortical hormone production."

" *Counter-shock.*"—In the state of counter-shock the pituitary has been stimulated, excess of A.C.T.H. is being secreted, the adrenal cortex is enlarged and is secreting an excess of its three different groups of hormones. In this phase there is a reversal of all the symptoms of shock. Where there was a low blood-pressure the pressure now rises ; where there was hæmo-concentration the blood is now diluted ; where there was first of all hyperglycæmia due to the release of adrenalin followed by hypoglycæmia in the shock phase, there is now a return once again to hyperglycæmia.

In addition to the reversal of the stage of shock as a result of the influence of the adreno-cortical hormones, in this phase of counter-shock there is a tendency for lymphoid tissue to disintegrate; the thymus, the lymph nodes and the lymphocytes involute. The break-down of the lymph nodes may be rapid and dramatic, and micro- organisms may invade the damaged tissue with the production of an inflammatory reaction. Inflammation of the appendix and the tonsil may take place in this way, for these structures are specially rich in lymphoid tissue. The disintegration of lympocytes releases γ-globulins and these are important for antibody formation which is the characteristic feature of the counter-shock phase. You will remember that in Addison's disease, a disease due to deficiency of adreno-cortical function, there is a lymphocytosis, whereas in the counter-shock phase there is a lymphopænia.

The Stage of Resistance.—If the organism has succeeded in weathering the phase of shock and of passing on to the phase of counter-shock it then proceeds to a more chronic state, the stage of resistance. This is a continuation of the counter-shock phase in which the organism has become inured to the specific " alarming " stimulus which originally caused the shock, but at the expense of all other " alarming " stimuli to which, during the stage of resistance, the body is abnormally sensitive. It is as though the organism possessed only a limited amount of " adaptation energy " which it employs in resisting the specific " alarming " stimulus, with increased sensitivity, or " crossed resistance " to other potentially damaging stimuli. Thus the organism is still capable of succumbing to the shock produced by other noxious agents.

The Stage of Exhaustion.—The stage of resistance may go on to a complete recovery, and the organism may regain its " homeostasis," to use Walter Cannon's expression.

On the other hand, the " alarming " stimulus may be so prolonged and so strong that the organism finally passes into the stage of exhaustion in which the symptoms again resemble those of the shock phase, and eventually death occurs.

Even with the persistance of the resistance stage one may begin to discern certain features of shock indicating that the stage of exhaustion is being reached. One classical example which received considerable attention during the war was the inurement of pilots to prolonged high altitude flying under stressful conditions. Not infrequently these men were grounded because they had developed peptic ulcers, which were an indication of the onset of the stage of exhaustion and of relapse into the condition of shock.

Diseases of Adaptation.—This hypothesis of Selye—the general adaptation syndrome—though not completely confirmed by other workers, has, however, been backed by a considerable amount of experimental work and most of the features I have described to you have been repeatedly obtained in experimental animals such as rats submitted to various types of stress, such as cold, trauma, etc. Out of this theory has developed the idea that certain disorders are in fact " diseases of adaptation " and are due to continued over-activity of one or other group of adreno-cortical hormones.

Take, for example, *Cushing's syndrome.* It is perhaps fortunate that this disorder is known by an eponym, because its pathology is still very difficult to understand. In one case we may find an adenoma of the pituitary ; in another an adreno-cortical tumour ; in another no changes of the pituitary other than diffuse hyalinization of the basophil cells ; in another a carcinoma of the thymus ; in another no disorder of any endocrine gland at all ; in yet another a carcinoma of the bronchus. It may be that Cushing's syndrome, though frequently due to some tumour in the endocrine system, is nevertheless merely a disease of adaptation due to the over-activity of adreno-cortical hormones and particularly of the sugar hormones. It is interesting to find that in connection with the experimental treatment of rheumatoid arthritis and numerous related conditions which is now being undertaken with " cortisone " and A.C.T.H., quite serious side-effects similar to certain features of Cushing's syndrome are being encountered. One small child suffering from Still's disease, a puny, emaciated creature, blew up with fat so that it looked like a little pig after the administration of A.C.T.H. Many cases so treated have shown the full-moon-shaped face, the plethora, hirsutism, and other features of Cushing's syndrome. Prolonged over-activity of the salt-and-water hormones can produce *hypertension,* and it may be that high blood-pressure and particularly essential hypertension are conditions arising out of a series of stresses and may therefore be diseases of adaptation. Take the condition of *nephrosclerosis.* Here, in the presence of hypertension, lesions develop in the renal arteries giving rise to diminished blood-pressure in the kidney, which in turn brings about increased production of renin and other pressor substances, probably liberated by the spiral segment of the convoluted tubules of the kidney. This renin and other pressor substances act on a_2-globulin, stored in the liver, and convert it into hypertensin which circulates in the blood-stream and further raises the blood-pressure, thus producing a vicious circle.

This sequence of events leading to nephrosclerosis has been reproduced in experimental rats by partially occluding one renal artery, so that the blood-pressure is exactly equal to the osmotic pressure of the plasma proteins. The kidney thus ceases to perform its renal functions and becomes merely an endocrine organ, liberating renin and the other pressor substances from the tubular cells. This very rapidly leads to a condition of marked nephrosclerosis in the other kidney, accompanied by other manifestations of high blood-pressure, such as *periarteritis nodosa* in the vessels of the mesentery and in some of the cerebral vessels. *Nephritis* itself has been produced in these experimental animals. If the nephrosclerotic condition is allowed to persist, actual inflammatory lesions develop in the kidney, and it is interesting to notice how frequently acute nephritis may follow a number of stressful conditions which may give rise to an alarm reaction, such as infectious diseases like scarlet fever and diphtherla, exposure to cold and nervous strains. *Acute rheumatism* with *Aschoff* nodules, typical endocardial vegetations, pericardial effusions and acute joint lesions have been produced in these experimental animals by the administration of deoxycorticosterone. It is probable that acute rheumatism is a disease of adaptation and follows again on a number of stresses such as cold or scarlet fever or some other generalised infection. *Rheumatoid arthritis,* and in some cases, gout have been produced in experimental animals by administration of deoxycorticosterone, suggesting that these may be diseases of adaptation due to the over-activity of deoxycorticosteroids.

One of the chief effects of over-activity of the 11-oxysteroids is lymphoid involution.

I have already mentioned the type of *appendicitis* which may result from disintegration of the lymph nodes of the appendix and invasion of the damaged lymphoid tissue by micro-organisms. *Tonsillitis* may also be due to rapid disintegration of lymphoid tissue of the tonsil with subsequent invasion by micro-organisms. It is striking how frequently tonsillitis follows some stressful condition such as cold.

Certain types of *diabetes* may be produced by over-activity of this hormone. I have already referred to it as the " sugar hormone " which converts protein into sugar, laying down glycogen in the liver and producing hyperglycæmia. In Cushing's syndrome hyperglycæmia and glycosuria commonly occur. Another condition which is of some interest is the *Waterhouse-Friderichsen syndrome* of bilateral hæmorrhagic necrosis of the adrenals, usually occurring in infants, or following meningococcal or staphylococcal septicæmia in later life, and probably due to over-stimulation of the adrenals by A.C.T.H. as a result of some stressful condition. The over-stimulation gives rise to actual hæmorrhages into the adrenal glands, producing dramatic and usually fatal results, the infant dying rapidly in a severe Addisonian crisis.

Other conditions may be due to adrenocortical exhaustion or deficiency. *Simmonds's disease* is due to a complete failure of pituitary function and frequently follows parturition. *Addison's disease* and *status thymico-lymphaticus* are manifestations of adreno-cortical deficiency and show very much the same symptoms as one finds in shock.

At first sight it would appear that the results recently obtained by Hench and his colleagues at the Mayo Clinic in relation to the relief of rheumatoid arthritis by means of Cortisone and A.C.T.H. conflict with the hypothesis of the General Adaptation syndrome. It would seem that one can produce rheumatism or rheumatoid disorders as the result of over-production of adreno-cortical hormones and that on the other hand one can cure rheumatic conditions by the administration of such hormones or A.C.T.H. The explanation may lie in the fact that most of the rheumatic disorders are brought about by over-activity of the deoxycorticosteroids, that is to say, the salt-and-water hormones, and not the 11-oxycorticosteroids.

Experimental formalin Arthritis.—Selye, in a series of brilliant experiments in the last few months, has produced, in rats, by the injection of formalin into the neighbourhood of the joint a severe form of arthritis. He found that when he administered deoxycorticosteroids to the rat at the same time as he injected the formalin the arthritis appeared rapidly and was extremely marked. He found also that if the rat was receiving a crude anterior pituitary extract containing a number of other factors in addition to A.C.T.H. (" lyophilized " anterior pituitary extract),the injection of formalin again led to a very rapid and severe arthritis. On the other hand, if the rat was receiving at the same time " Cortisone " or purified A.C.T.H. this formalin arthritis did not appear at all. In other words, the rat was completely protected from this type of arthritis by the administration of purified A.C.T.H. or of " Cortisone."

It would seem that many of these disorders of adaptation are due to a shift in the adrenal cortical hormone balance. Most of them are clearly due to over-activity of deoxycorticosterone and substances of similar chemical nature. We may, perhaps, regard deoxycorticosterone as the bad fairy of the pantomime and 11-oxycorticosteroids or " Cortisone " as the good fairy, the latter relieving the conditions produced as a result of maladaptation or over-activity of the deoxycorticosteroids.

The need for Metabolic Studies.—It may be that it is not so much a question of what the adrenal cortex is actually secreting at any one time, whether it is secreting an excess of 11-oxysteroids or an excess of deoxycorticosteroids ; it may be a metabolic problem. It may be that when these substances reach the blood-stream thay are converted into other chemical substances which may either produce the lesions or protect the organism from them. It is quite clear that there is a tremendous field of investigation to be explored in relation to the metabolic effect of these adreno-cortical hormones. For instance we know practically nothing of the form in which these adreno-cortical hormones are excreted. Deoxycorticosterone acetate does not appear in the urine, although there is some evidence that it may increase the pregnanediol level of the urine.

Therapeutics.—The therapeutic field, at the moment, is alive with fantastic rumours and incredible stories of cures of everything from corns to cancer, and it is difficult to obtain a well-balanced picture. There seem to be indications however that lymphoid disorders, such as lympho-sarcoma, lymphatic leukæmia and Hodgkin's disease may respond to A.C.T.H. or cortisone. Sensitivity reactions, for instance to penicillin; asthma and other allergic phenomena ; and numerous skin disorders, especially of mesenchymal tissues, also seem to be relieved, in addition to rheumatic disorders of all kinds. In the realms of surgery and obstetrics, it also seems clear than when adequate

quantities of A.C.T.H. and 11-oxysteroids are available they will serve as very valuable weapons with which to combat shock of all types.

Though at the moment there is considerable confusion in the therapeutic field, the future seems full of the promise of really exciting achievements.

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Round and Round

TEACHING rounds in the wards are probably one of the oldest as well as the most prominent features of training for medical students at Guy's. This has been so from the earliest days, when those giants whose names we now hold in awe dominated the assemblage of students following them from bed to bed.

The only rounds which ever bore us are those when we can't hear what is being said. All the others, good and bad, have their own characteristics and always have something to offer us. There are the Registrars' Rounds. These, varying though they do with the personality of the Registrar are, on the whole, businesslike affairs—start at 10.30, stop at noon—basic teaching and no frills. Honoraries rounds, however, vary more in character. There is the Round which is very general and which teaches you how to handle a patient rather than differential diagnosis. Then there is the clear cut, " Plain man's guide to medicine " round. There is the robust round, the genial round, the homely round, the confidential round, and all have their place and all their value, and personally we like a bit of each. Lastly, there is one other type of round—the Voluntary Round—the sort of round which might take place, say, on a Tuesday afternoon at 5.30. This is different from the others. You come on this one " at owner's risk." You may drop what bricks you like, always provided you don't mind being made to pick them up and amidst an 'orrid 'ush drop them again for all to hear and, incidentally, for you to remember ever after. And this sort of round, though genial, robust and homely, is no place for the diffident. Some indeed manage to hide at the back and escape unnoticed. Others do not. These others—and we know just how they feel—probably learn most, but there are times when having failed dismally to palpate a spleen or remember who Medusa was—there are times when one feels just like J. Alfred Prufrock. . .

> No, I am not Prince Hamlet, nor was meant to be ;
> Am an attendant Lord, one that will do
> To swell a progress, start a scene or two,
> Advise the Prince ; no doubt an easy tool
> Deferential, glad to be of use,
> Politic, cautious and meticulous
> Full of high sentence, but a bit obtuse
> At times, indeed almost ridiculous
> Almost, at times, the Fool.
>
> . . . . .

Yet, oddly enough, we always come back to another Voluntary Round.

WILLS LIBRARY

The following books have been borrowed from the Library without signature. Will the borrowers please return them as soon as possible.

Atkins : After-treatment. 3td Edn. Blackwell, 1946. 2 copies.
Bailey : Physical signs in Clinical Surgery. 10th Edn. Wright, 1948.
Birch : Medical Emergencies. Livingstone, 1948.
Collyer & Sprawson : Dental Surgery. Longmans, 1948.
Himsworth : Diseases of the Liver. Blackwell, 1947.
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The Third Journey

By DAVID STAFFORD-CLARK, M.D.

THE tradition of travel is a strong one at Guy's. Particularly since the war, the generous arrangements made possible by this hospital and the Johns Hopkins have enabled many Guy's men, representing almost every stage in their professional career, to cross the Atlantic and work in America. During the war and since, Guy's has benefited by a similar exchange of American doctors who have left a profound and most pleasant impression behind them. The *Gazette* has many records of these visits, some written by our most distinguished physicians and surgeons, describing in detail not only travel but techniques studied at first hand and absorbed with a craftsman's skill; others vividly described by students whose adventures have left them wonderfully stimulated and excited by vast distances, great enterprises, and magnificent hospitality. Many of us have read, and will not forget, " An American Diary " and " Some Lessons of the Exchange "; more recently, two articles on the student exchange have reached readers of the *Gazette* in Massachusetts and have been eagerly studied. Indeed the subject of Englishmen in America is one which, to transcribe T. S. Eliot's lines from another context:—

" . . . has already been discovered. Once or twice,
Or several times, by men whom we cannot hope to emulate—
But there is no competition—. . . ."

No competition, only perhaps other experiences, some different, some similar, in a land of inexhaustible variety. A year ago I made two journeys in Europe and endeavoured to describe them. This is a third journey.

I was supposed to come to America on the *Queen Mary*. Once, as a student, returning from a remarkable holiday to take up my duties as a dresser on Mr. Layton's firm, I had travelled tourist on this ship from New York to Southampton; it was the voyage on which the blue ribbon was won, and my recollection is a confused one of exhilaration, gaiety (sometimes a trifle synthetic), and through it all the ponderous vibrations of those enormous engines turning over faster than they had ever turned before. I had enjoyed it immensely. I did not look forward to the outward voyage with comparable enthusiasm, because to leave one's wife and children for what may be a full year and to take up again the burden of an artificial and circumscribed bachelorhood, made only too familiar by the war, is not conducive to the kind of mood appropriate to Trans-Atlantic liners. So I was delighted when, for various administrative reasons not relevant to the theme of this article, it became necessary for me to cancel my sea passage and to travel by American Overseas Airways.

In the airlines bus going to Heath Row, I sat next to a young American student who had spent six weeks doing Europe. From a British point of view, he had apportioned his time in a rather flattering way, having spent two weeks in England and four weeks divided between the rest of the Continent. Of many vivid experiences, the one which he remembered most enthusiastically was a round of golf with a distinguished English gentleman on a French golf course. He had met his opponent on the first tee, both apparently waiting for a partner to arrive; after about 20 minutes, as they were still alone, he invited the stranger to play with him. They proceeded amiably on their way until about the fourth tee, when my friend had said: " Excuse me, but haven't I seen your picture somewhere before? "

" You may have," replied the stranger with quiet courtesy.

" If you will forgive me saying so, you look rather like the King of England."

" Well—that's understandable; I'm his brother."

. . . " You know," said my friend after telling me this, " I'm wondering if they'll believe me back home when I tell them that I played a round of golf with the Duke of Windsor! "

" I believe you," I said.

The aircraft took off punctually at 7.15 p.m. At 5,000 feet, circling Heath Row, the pilot announced we were about to set course for Shannon. Two minutes later the port inner airscrew was feathered, and 20 minutes later we had landed again in Heath Row. We spent five hours being shepherded gently through various reception rooms to a hotel where an impromptu, but excellent, dinner was provided, and where most of the passengers fretted about schedules or embarked upon ancedotes of fatal crashes involving their neighbours or acquaintances. Waiting in the lounge of this

quiet country hotel, apparently requisitioned by the joint airlines for such contingencies, I found the atmosphere reminiscent of war-time periods between briefing and take-off, when the operation had been postponed. There was the same impulse to call up someone in the outside world on the telephone and explain that you were still here, but for different although similar reasons, I resisted it. My wife had every reason to believe I was well on my way. It seemed better not to disturb that impression.

We eventually took-off soon after midnight and landed at Shannon something over two hours later. There we were served with the second dinner of that trip, designed for consumption some five hours previously. With that opportunist voracity which now inevitably distinguishes the Englishman abroad, I ate the whole lot. An hour later we were on our way again, and as the Trans-Atlantic part of the flight took us nearer and nearer to the roof of the world, and higher and higher into the sky, we were flying in bright sunlight above an unbroken belt of dazzling white clouds at 4 o'clock in the morning. Time, of course, becomes hopelessly complicated on these journeys. Some passengers dutifully put their watches back an hour at hourly intervals, others wrestled with the difference between Greenwich mean time, the British double summer time, Eastern standard time, and whatever time anybody thought it was in the airplane. An American lady who had just about as far again to travel to her home in California after landing at New York was anxiously scanning an American Airlines time-table and drafting a succession of cables to her husband. Later the clouds lifted, and 18,000 feet below were the waves of the Atlantic seeming tiny and individually motionless as they flowed under the wing of the aircraft. The passengers slept and woke, had snacks, wrote postcards, talked to the hostess, and slept again. Hours, or perhaps years later, we sighted Newfoundland, floating like a lace dinner-mat upon the surface of the Atlantic. The outer fringes of this land mass seen from the air appear like an archipelago with the islands loosely joined by narrow peninsulas; at this stage, one has no doubt that the water surrounding them is still salt. Further inland, the picture changes almost imperceptibly until there are innumerable fresh-water lakes surrounded by wooded land which gradually widens until it gains at least the appearance of solidity. Then we landed at Gander in a fine drizzle of rain and once again had a meal—which I suppose must have been breakfast, while the more obsessional travellers worried about the inevitable discrepancy between their watches and the airport clock.

The remainder of the flight from Newfoundland across Nova Scotia and the Gulf of Maine brought us to Boston, and for me the crossing was at an end. Right from the beginning, the fact that I was an English doctor going to work at the Massachusetts General Hospital proved an asset. The Customs man assured me of my wisdom in selecting this institution and explained how a grandmother had been cured of varicose veins here after many other clinics had done their best and failed. A great friend, an American doctor whom I had originally met when he was over in England at the National Hospital, Queens Square, had come to the airport to meet me, and at his house I spent my first American week-end.

The Massachusetts General Hospital is one of the most famous hospitals in America, the first to be founded in New England, the third in the United States; the oldest buildings were constructed in 1821, and include the famous Bullfinch Building and the Ether Dome already mentioned by both the Guy's men who visited here and wrote of their experiences in a recent issue. This vast general hospital includes, with the Eye and Ear Infirmary, 1,038 beds and has a comparably large resident staff of all grades of experience from internes to senior residents. Appointment in any capacity is one of the most highly competitive distinctions in the training of an American doctor, and a consideration of the way in which the staff function will show why this is so. The entire clinical organisation and day-to-day functioning of the hospital depends upon the resident staff to a greater extent, perhaps, than in England. My own experience is based upon work in the department of neuro-psychiatry, but the same principle holds good for all other departments. The status of resident is comparable to that of registrar or first assistant in an English hospital, and interne to that of house physician or house surgeon. The residents are responsible for the running of the wards in their departments, for the supervision and guidance of the internes, and for all consultations between one department and another. They are also responsible for consultations in the Emergency Ward, which corresponds to the Front Surgery at Guy's but has the additional advantage of being equipped with a 27-bedded ward with full nursing staff and facilities for the care of medical and surgical cases, where patients can be retained for observation up to 48 hours before either being admitted to the main hospital, transferred elsewhere, or discharged. The Emergency Ward is staffed by internes under the direction of one medical and one surgical resident, both of whom do duty for a week at a time and then

are replaced by other residents from the general medical and surgical services much in the manner of the R.M.O. or R.S.O. at Guy's. But a call for consultation by the resident on duty for a particular service is invariably put through whenever a patient presenting problems relevant to that service is seen. In this way the residents have opportunities of widening their experience in three main fields : the normal work of their own department with in-patients and out-patients in their own wards and clinics ; the application of their speciality to every other department in the hospital whenever they are required to carry out a consultation for another department ; and the immediate handling of emergencies of all kinds which bear in any way upon their specialty in the Emergency Ward.

On the neuro-psychiatric service there is yet another aspect of experience open to the resident staff, since in addition to the normal neuro-psychiatric ward in the Bullfinch Building there is also a small disturbed ward containing four beds and designed for the reception of delirious, psychotic, or otherwise unmanageable patients from every other department of the hospital or from the Emergency Ward. As can be imagined, this is sometimes the scene of considerable activity, although it is rare for patients to be retained there for very long. It affords the nearest approach to the English Mental Observation Wards, where acute psychiatric emergencies are regularly seen, but which unfortunately few students have encountered in their training or even know exist. The opportunity of seeing the acute psychiatric emergency handled and controlled with the minimum of disturbance, and very frequently restored to a very much more tractable condition within 48 hours, is one which would provide a very real advantage to men training for general practice where such emergencies are liable to confront them in private homes, as well as to students proposing to make this branch of medicine their special interest.

On the neuro-psychiatric service, most of the inter-departmental consultations are concerned with psychosomatic problems on which a considerable amount of research has been and is being conducted at this hospital. But the degree to which other services make use of psychiatric consultations far exceeds anything which I have previously encountered in England, and includes, for example, all forms of toxic confusional state and delirium, as well as the emotional reaction of patients to multilating operations or intractable pain. Altogether, it is a most stimulating and encouraging enviromennt in which to work and opens up possibilities for the integration of a well-equipped psychiatric service in the day-to-day workings of a general hospital which have proved their value in America and are of immense encouragement to those who believe in their application in England.

The experience of working in intimate contact with the patients who surround the Massachusetts Hospital in Boston is a warm and pleasant one. Like most Guy's men, I have a private conviction that there is nothing quite like the Borough anywhere else in the world, but in their essential humanity, courage, good humour, and loyalty to their institution, the patients of both hospitals are more remarkable in their similarities than in their differences.

There is also a special fascination about some of the hospital employees. The man who works the elevator in the Bullfinch Building which takes me to the third floor wards where I work every morning is called Ippolito Salvitore. He is a gentle, charming, Italian-born American of modest stature who habitually wears the cut-off end of a brown paper bag as a hat to cover his bare scalp, and who spends his time when not actually operating his little cell by studying the natural sciences. A month ago it was trigonometry, and from time to time he would consult me about a problem until my shameful ignorance became apparent. Now it is biology, and we are on familiar ground. A week or two ago just as I was about to step out on the third floor, he said : " Excuse me, doctor, but I have a problem here."

" Certainly, Sal ; tell me what it is."

" The leucocytes, doctor—are they inside the capillaries or outside the capillaries ? " I call that a complicated question. I did my best.

" Well, Sal, sometimes they're inside and sometimes they're outside. When there is an infection, they can migrate outside to deal with it."

His face lit up. " Why, doctor, would that be the migration of the leucocytes ? "

" Yes, I suppose it would."

" Well now, isn't that something ? "

More recently, as we were grinding aloft (the Bullfinch elevators have not the dazzling efficiency of the more modern part of the hospital), he extended the palm of his hand toward me to display two small green pellets.

" Do you know what these are, doctor ? "
" No, Sal, I have no idea."
" Well, they're guinea pig food."
" But I thought guinea pigs ate grass."
He smiled proudly. " Yes, but these are synthetic guinea pig food with added vitamins."
" You astound me. But wouldn't grass do just as well ? "
" Well you see these guinea pigs live on the top floor and their ain't much grass around."
" I understand."
I made as if to go, thinking we had exhausted the subject, but Sal beckoned to me. " There's just one disadvantage to these tablets, though."
" Yes ? And what is that ? "
" They make the guinea pigs' excrement smell something horrible."
Smiling wisely, he stepped back into his cage and sank slowly from sight.

(To be continued)

NOTE BOOK

THERE can be few places where Christmas decorations are so beautifully done as in the wards at Guy's. Most of us in our homes decorate with a more or less traditional mixture of holly and coloured paper, and however much pleasure the result may give us we should probably admit that though always better, of course, than our efforts the previous time, they do not differ very remarkably from year to year. Not so at Guy's. Each year, each ward takes some theme and by a remarkable mixture of planning, cunning, enthusiasm and hard work, the wards in the two days before Christmas become virtually transformed. The result varies from the gracious, the the attractive and the pretty to the really beautiful. We have seen wards transformed into villages, made to represent scenes from mediæval England and with many variations in between. This year the results were worth coming a long way to see. There are many we should like to mention. Just two will give you some idea. Addison Ward has a flashing lighthouse outside the door, a lifebelt on the door, a helm in the centre of the ward, and the whole ward rigged with nautical decorations, even to the patients who, when we looked in, were wearing sailors' hats. Visiting Sarah Swift Ward was like entering some beautifully coloured grotto out of the Arabian Nights, each bed a sweet stall, the whole ceiling hung with colours, the end of the ward a deep blue oriental sky behind minarets, floodlit from the ceiling, and from behind a screen came soft symphonic music : almost a surprise to find the music came from a radiogramophone and not some hidden choir or orchestra. We almost envied the patients, in fact one year we shall have to make ourselves ill before Christmas. . . .

W. H. SMITH'S bookstall faces towards the Physiotherapy Department of which Dr. Crisp is the head. Last week a bright orange signpost suddenly appeared between them, " Smiths " and " Crisps " upon its two arms. Since the Works Department denied responsibility the signpost disappeared. We think we know in which direction. . . .

SATIRE in the Sports columns of *The Gazette* seems to be out of place. The account of a recent rugger match when the Tankards did actually win 37—0 has been taken literally by several people. For the benefit of these we record that the game played was Rugby Football, that it was played with an oblong and not a spherical ball, and that there were actually 15 players on each side, all of whom knew they were allowed to use their hands and feet. We can further assure our readers that the Tankards do actually drink the beer they hold in their hands. Some of you may have observed their captain doing so, not only after a Tankards' match either.

THE other evening an exceedingly dirty, disreputable and somewhat grotesque character came to the Hospital asking to see his son. He bore the most peculiar resemblance to Fagin. Three students offered to escort him and he was allowed to enter. Half-way down the Colonnade he broke into a shambling run and, eluding his escort, disappeared. An unsuccessful man hunt followed in which a few members of the staff took part, but the victim appeared to have a superior knowledge of the underground passages and vanished so that the chase was eventually given up—a most odd incident. Even more odd, however, is the resemblance of one of our friends to this character. Indeed, persons less charitable than ourselves might just perhaps have had a sort of suspicion. . . . Ah well, one expects the pages of Dickens to come to life at Christmas time.

"I've Stood in This 'Ere Market Place—"

By EL HAKIM PASHA.

A CO-EXAMINER of mine with a natural flow of language once let himself go on "the inability of students to express themselves on paper" and he made some blistering comments on handwriting and spelling. As I sat up until 2 a.m. that morning marking papers, I knew exactly how he felt about it and he had my heartfelt sympathy.

As soon as I was qualified I wanted to see my name in print, so I wrote an article, and in a state of transcendental elation posted it to the editor of a famous medical paper. A few months ago I found an old reprint and read it—after more than thirty years. What on earth the editor could have been thinking about to publish it I never cease to wonder. I go hot all over every time I think of it. I feel that I shall never live it down, callow tripe that it was!

Newly qualified men of to-day have a great advantage (or disadvantage?) over those of my youth, for manufacturing chemists of to-day excrete never-ending reams of bumph and are only too willing to print laudatory remarks from users of their preparations, usually under initials.

I recently received a "*brochure*" from such a firm dealing with a new preparation of acetylsalicylic acid of which they were clearly very proud, and it contained extracts from over 500 eulogia.

Acetylsalicylic acid tablets can now be obtained from slot machines almost as easily as contraceptives, in many "locals." When I see fellow-citizens putting three or four of them—tablets of course, not contraceptives—"down the hatch" with a draught of anything that happens to be handy—even water at a pinch—it gives me an attack of pylorospasm and I get a vivid mental picture of their gastric mucosa.

But to return to our "*brochure*": let me quote:—

"I have a very old lady with a chronic gastric ulcer, taking it without harm."

Has he, I wonder? When I think of very old ladies with chronic gastric ulcers the first thing that occurs to my mind is malignant neoplasm, and I should not be able to sleep in my bed until I had excluded it.

Or again:—

"As a personal sufferer from duodenal ulcer I have difficulty in relieving headaches by the usual analgesics of the aspirin group, but your preparation does not have (sic) any gastric upset."

("Usual analgesics of the aspirin group."—I like that. It's got *style*!)

As Dudley Davenport might say, "I may be a fool," but I don't think I would like to prescribe, or take, aspirin with a duodenal ulcer. But as for my headaches, I should wonder whether I had any large bowel stasis and whether it might not be wise to see an eye man?

Another doctor says:—

"I have a duodenal ulcer and ordinary acetylsalicylic acid preparations give me heartburn, *often marked*. I have taken your preparation with complete freedom from digestive upset." (*The italics are mine.*)

I wonder whether these are cases of self-diagnosis? I have recently been consulted by two doctors for suspected duodenal ulcer, of which they were certain. Both had been over-working, suffering from insomnia, and regularly taking aspirin at bed-time—gr. 10 to gr. 15. In each case a barium meal showed no sign of ulcer but a very considerable degree of pylorospasm. Both were typical examples of the duodenal diathesis in which it is much more important to treat the patient than the ulcer. Both got almost immediate relief from mixtures containing Pulv. Mag. trisil gr. 40, Pot. Brom. gr. 10 and Tinct. Bellad m. 12–15 t.d.s.

I remember reading a very interesting Scandinavian paper on "Duodenal Pain" in which it was stated that the pain in duodenal ulcer is very largely due to pylorospasm, and that a barium meal or gastroscopy may show no demonstrable ulcer. I have proved the truth of this.

One gentleman delighted me by modestly describing himself as an "extensive tonsillectomist" and considers the preparation "of use to relieve the soreness and pain after the operation."

Has the *Gazette* no tame artist who can give us his conception of "an extensive tonsillectomist"? It conjures up a picture in my mind's eye but unfortunately I am no artist. We've all met them, of course, often in connection with Cottage Hospitals in the country. And, oh Boy! we've seen some of their results.

Another gentleman lauds the preparation as "ideal for those afternoon headaches associated with overwork." I may be quite wrong, but I should again think first of an overloaded colon and then of an eye man.

Do you remember Kipling's "Sergeant's Wedding"?—"Now you 'oly beggars, corf be'ind your 'ands"? You do? Well what about a gentleman who finds the preparation useful to "suppress a headache without drawing attention to the fact"? Why? Are they immoral, or obscene?

I could go on quoting all day, but the above are enough for my purpose.

What lessons are to be learnt from all this?

First of all I think it unfair for manufacturers of drugs to tempt young doctors to write to them in praise of their preparations and publish extracts which make the doctor look foolish. When I think of the "very old lady with a chronic gastric ulcer," and the doctors who, with active duodenal ulcers, give themselves acetylsalicytic acid—well I may be wrong but it makes me hot with shame. I cannot imagine such ignorance in Guy's men.

Some drug houses publish most informative and meritorious "brochures" and some doctors seem to rely on these as they would on a text-book, and are liable to develop a *cacoethes scribendi* of an unfortunate kind. I have seen, as many of you must have done, statements made lightly by these budding authors of an *ex cathedra* nature, which in tomorrow's sunlight look like gibberish—when it is too late. Perhaps even your name *might* be mentioned. It happened to me many years ago and *might* happen to you.

So do not rely on manufacturers' advertisements for keeping your medicine up-to-date; and don't write laudatory letters to manufacturing chemists. If you do, don't be surprised if they are published!

Guy's Diary

ACADEMIC

January		Exhibition. Surgical Department. "Pott's Disease."
2nd.	1.00.	Dr. Crisp. Clinical Lecture. "Body Mechanics."
	3.30.	Dr. Forman. Demonstration of Skin Diseases. Preclinical Classroom.
	5.00.	Department of Child Health. Film Show. "Cross Infection in Maternity Units." Anatomy Theatre.
3rd.	1.00.	Dr. Baker. Clinical Lecture.
5th.	1.00.	Mr. Grant Massie. Clinical Lecture.
6th.	1.00.	Dr. Kauntze. Clinical Lecture.
	2.15.	Combined Round. Preclinical Classroom.
9th.	1.00.	Dr. Wayte. Clinical Lecture.
13th.	1.00.	Dr. Campbell. Clinical Lecture.
	2.15.	Combined Round. Preclinical Classroom.
14th.	10.00.	Mr. Norman Tanner, St. James' Hospital, Balham. Surgical Departmental Round. Clinical Theatre.
16th.	1.00.	Mr. Batchelor. Clinical Lecture.
	5.00.	Department of Child Health. Film Show. "Journey into Medicine." Anatomy Theatre.

OTHER ENGAGEMENTS

January	
7th.	Rugby XV. *v.* Old Merchant Taylors. (H.O.P.).
	Hockey 1st XI. *v.* South Saxons. (Away).
	Hockey 2nd XI. *v.* South Saxons. (H.O.P.).
	Association Football 2nd XI. *v.* National Provincial Bank. (H.O.P.).
14th.	Rugby XV. *v.* Wasps. (H.O.P.).
	Hockey 1st XI. *v.* Hendon. (H.O.P.).
	Hockey 2nd XI. *v.* Hendon. (Away).
	Hockey 3rd XI. *v.* Hendon. (Away).
	Association Football 1st XI. *v.* Alleyn Old Boys. (Away).
	Association Football 2nd XI. *v.* Alleyn Old Boys. (H.O.P.).

Mass Radiography

By T. H. HILLS, M.B., D.M.R.E.

Readers of the *Gazette* may be interested in a brief résumé of the results of the recent Mass Chest X-ray.

Anyone who is employed by the Hospital was invited to attend, and the following figures will show that the response was moderately good.

The value of this investigation is chiefly the detection of early tuberculosis, and five new cases were discovered. I have divided the figures to show the response from those groups who in any case come under an organised Health Service from those whose attendance was entirely voluntary.

It is hoped that this X-ray unit will come to the Hospital twice a year in the future.

	No. expected to attend (Males)	*No. X-rayed (Males)*	*No. expected to attend (Females)*	*No. X-rayed (Females)*
GROUP I. *Organised Health Services.*				
Medical and Dental Students	937	919	55	48
Nurses	—	—	561	484
Radiographers and Physiotherapists	—	—	195	163
GROUP II.				
Hospital Secretaries, Clerks, etc.	20	12	118	109
School and Hospital Technicians	unknown	74	unknown	28
Kitchen Staff	36	1	13	2
Domestic Staff	—	—	294	82
Porters	44	32	—	—
Works Dept. Staff	210	19	—	—

Reviews

Brompton Hospital Reports. Vol. XVII. 1948. Published by and obtainable from The Hospital for Consumption, Brompton Road, S.W.3. *Price* 10*s.*

Here is a collection of papers (all of which have recently been published elsewhere) from a very famous hospital. As is their custom, they have done it well, with a nice cover, good paper, and clear print and illustrations. Included are: "The Brompton Hospital: A Centenary Review" (Hoyle); "The Pneumonias associated with Epidemic Respiratory Infections" (Scadding); "Some Atypical Primary Tuberculous Lesions" (Macpherson); "Cerebral Metastasis in association with Intrathoracic Disease" (Davidson); "Medical Contraindications to Flying" (Robson); "Pulmonary Valvulotomy for the Relief of Congenital Pulmonary Stenosis" and "Recurrent and Chronic Spontaneous Pneumothorax" (Brock); "Extraplural Pneumothorax" (A. T. M. Roberts); "Advances in Thoracic Surgery" (Barrett).

Handbook of Dental Surgery and Pathology. By ALWYN F. PERKINS. 1st Edn. Sylviro Press. *Price* 30*s.*

This book is, as stated by the author in the preface, an attempt to bridge the gap between voluminous textbooks in Dental Surgery and the shorter condensations found in cramming books. For the greater part it does this very well and can be recommended to those who require a rapid survey of the dental field before sitting for the finals or even the F.D.S. The danger attached to books such as these is that they might be used without recourse to more extensive reading.

There are a number of inaccuracies, particularly when the author is dealing with medical matters, and the section on purpura should be entirely revised. This applies also to some of the classifications adopted, many of which are unnecessarily extensive and only serve to make what might be a useful little book into one containing too many irrelevant details. Part II which deals with Dental Anatomy, Embryology and Histology is an excellent summary of the various subjects under discussion. J.H.

Sport

RUGBY FOOTBALL

Guy's *v.* Moseley

Away. Won 11—3.
December 17th, 1949.

Guy's beat Moseley on their own ground by one goal, 1 try, and 1 penalty goal to a penalty goal. Moseley attacked hard from the start and in the first few minutes were unlucky with two penalty kicks at goal, one of which hit the post. The Guy's forwards rallied and rushed the ball into their opponents 25. From a heel K. Heber forced his way over to score a try which Davies converted. Both sides attacked after this and some good open rugger was seen. Guy's went further ahead when Davies kicked a penalty goal.

After half-time the concerted Moseley attacks rattled the pack and tested the defence of the back division which remained sound. Rademan, Bellis, and Grey were particularly conspicuous in defence. Finally E. Wright kicked a penalty goal for Moseley.

In the last hectic minutes F. le Clus picked up a loose ball and ran well before sending in W. Birch for an unconverted try.

To win against the strong Moseley side on their ground is something that Guy's can feel pleased about. They are becoming more confident now.

HOCKEY

Guy's *v.* Birmingham University

Away. Won 8—3.

As this was one of our most important fixtures of the season, a complete 1st XI. team turned out despite it being a Wednesday match. The team or most of it met at Paddington at 9.10. One player and our only supporter arrived late to see the train pulling out and only caught it by a display of energy hardly equalled in the game to follow.

We bullied off after lunch and despite the beer and suet pudding Guy's surprised Birmingham and themselves by scoring two quick goals, one by Earl and the other by Opie.

This was but a flash in the pan for we were forced back on the defence and for a quarter of an hour gave away, almost continuously, short corners. Although Birmingham finally scored from the last one, their general lack of success was due almost entirely to Murray, who tank-like charged out to collect either a ball on his shins or a spray of mud in the face.

Half-time came after Opie had scored again with a lovely "reverse sticks" lob over their goalie's head, to make the score 3—1.

We changed straight over as the light was failing and a drizzle had started. The play slowed down, largely through exhaustion, and became somewhat scrappy. Earl scored again in the first five minutes of the 2nd half. Before long the score was increased to 5—1, a cracking shot from Duckworth to the top corner of the net, causing everyone to duck. Twice more Birmingham broke through to score, but each time a goal was taken in retaliation and the game was largely in their half. At the final whistle Opie had scored 4, Earl 2, Blake and Duckworth 1 each, but though the score was not perhaps a true guide to the run of the play, our forwards were certainly very much the better.

We play a return match in January and they intend to bring down a stronger side. It should be a game worth watching.

BOXING

Guy's Lose to Metropolitan Police (5—1)

In a good programme at Streatham Baths on Tuesday, December 13th, a more experienced and fitter Metropolitan Police team beat Guy's by five bouts to one.

W. Sheeran, in the first of the team fights, was undoubtedly the harder hitter and more polished boxer; he appeared unlucky to lose on points to P.c. Woods.

B. Cremin, in only his second fight, was altogether too much for P.c. Dunham and provided the sole Guy's victory. Dunham retired at the end of the first round in which he failed to sustain an avalanche of blows that put him down three times.

Results.

P.c. Woods beat W. Sheeran on points.
P.c. Dunham lost to B. Cremin, retired after round 1.
P.c. Page beat J. Kirkbride on points.
P.c. Walters beat R. C. C. Thompson on points.
P.c. Boff beat D. Clarke, fight stopped in round 2.
P.c. Gillham beat N. St. John on points.

Hospital Information, etc.

APPOINTMENTS VACANT

GUY'S HOSPITAL

YORK CLINIC FOR PSYCHOLOGICAL MEDICINE, RESIDENT HOUSE PHYSICIAN

Applications are invited from qualified medical practitioners, who wish to take the D.P.H., for the post of **Resident House Physician** (B.2): duties to commence on February 1st, 1950. The appointment will be for six months in the first instance, and may be renewed for further such periods. The salary of the post will be in accordance with the Terms and Conditions of Service for House Officers in the National Health Service. Applications, accompanied by copies of two testimonials, should be sent to the Superintendent, Guy's Hospital, London Bridge, S.E.1, not later than January 20th, 1950.

RESIDENT MEDICAL OFFICER.

Applications are invited for the post of **Resident Medical Officer** (Male) in Nuffield House (Private Block), duties to commence on February 1st, 1950. The post will be tenable for six months in the first instance. The appointment is graded as "Junior Hospital Medical Officer," *i.e.* salary will be at the rate of £700 per annum for an officer appointed not less than two years after registration as a medical practitioner, less £100 per annum for board and lodging. Applications, six copies, accompanied by three testimonials, should be sent to the Superintendent, Guy's Hospital, S.E.1, on or before January 14th, 1950.

THE SIR ALFRED FRIPP MEMORIAL FELLOWSHIP IN CHILD PSYCHOLOGY.

Applications are invited for **The Sir Alfred Fripp Memorial Fellowship in Child Psychology** from medical graduates, men or women, under the age of 35, preferably with experience in Pædiatrics as well as in Psychological Medicine. Stipend £150 a year. The appointment is for two years and may be held concurrently with a part-time appointment elsewhere. Applications should be forwarded to the Dean (from whom copies of the regulations may be obtained), together with the names of three referees. Applicants should submit a definite scheme of advanced study or research work to be carried out during the tenure of the Fellowship together with particulars of their previous career. Applications should be forwarded by 5th January, 1950.

CORRECTION

With reference to the announcement (p. 408, G.H.G. 17/12/49) under the heading "Scientific Films," no charge was made for admission.

PASS LIST

UNIVERSITY OF CAMBRIDGE

FINAL M.B. EXAMINATION.

Michaelmas Term, 1949.

Part I.—Surgery, Midwifery and Gynæcology.

A. S. F. Butcher
J. W. B. Dalgleish
B. O. L. Duke
K. W. Gray
G. Holden
K. G. P. Mackenzie
G. N. St.J. Penney
D. R. Pugh
M. Rayne
J. R. Rees
P. L. Williams

Part II.—Principles and Practice of Physic, Pathology and Pharmacology.

R. Baxter
*R. G. Beard
*M. J. Hunter
*M. Rayne
*K. F. Robinson
*R. H. R. White

* Have now completed the examination.

CONJOINT BOARD

M.R.C.S., L.R.C.P.

FIRST EXAMINATION.

December, 1949.

Anatomy.

L. W. Kay
M. S. Tyrell

Physiology.

L. W. Kay
M. S. Tyrell
R. M. Saldanha

Pharmacology.

D. G. E. Alldridge
D. B. Amos
T. K. H. Boenheim
J. K. H. Culverhouse
G. H. Fisch
J. C. Gazet
N. B. Gillison
D. J. Green
R. D. Hernaman-Johnson
J. C. M. Heylen
B. L. Mallett
P. M. J. O'Brien
S. A. C. Paget
W. J. Pryn
T. G. Pugh
E. J. Rolls
G. L. Shaw
F. C. Shelley
K. G. Somers-DeHaney
M. A. Sorefam
R. V. Steward
A. V. Watts
C. H. Wilkinson

ROYAL COLLEGE OF SURGEONS OF ENGLAND

F.R.C.S.

FINAL EXAMINATION.

October, 1949.

A. Brown
G. D. Channell
A. G. Parks
H. A. Ripman
N. J. Shah

UNIVERSITY OF LONDON

Diploma in Psychological Medicine.

October, 1949.

R. J. Stanley, M.B., B.S.

UNIVERSITY OF OXFORD

Michaelmas Term, 1949.

Medicine, Surgery and Midwifery.

M. Brookes.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

L.D.S.

December, 1949.

FIRST EXAMINATION.

Anatomy and Physiology.

R. C. Jeffery
N. E. Malyon
C. B. H. Owen
I. L. Thomas

Special Anatomy and Physiology.

A. E. Castle
J. A. P. Darvell
P. N. Dawson
R. F. Hall
D. K. Hardy
J. Lopian
W. F. Reading
G. H. Tucker

ROYAL COLLEGE OF OBSTETRICIANS AND GYNÆCOLOGISTS

Diploma in Obstetrics.

A. R. Cini
R. L. Edwards
R. N. M. Eminson
R. D. C. Hart
J. Walsh

SOCIETY OF APOTHECARIES OF LONDON

FINAL EXAMINATION.

November, 1949.

Surgery.

*S. A. Jolliffe
D. H. le Clus
J. F. le Clus
*J. A. Payne

Medicine.

*A. R. Davis
J. F. le Clus

Midwifery.

*C. D. Bulstrode
*J. A. Payne
D. R. Pugh
I. A. W. Scott

* Have completed the examination.

PAPERS BY GUY'S MEN

Clarkson, Patrick. Surgery of Orthodontics. *Brit. Surg. Pract.* (Butterworth), 1949, Vol. VI.

Clarkson, Patrick, and Kenshole, H. H. Esmarch's Operation for the Relief of Ankylosis and of Pain in the Temporomandibular Joint: A modified technique. *Brit. Dent. J.*, 1949, **87**, 257.

Cross, W. G. Penicillin in the Treatment of Dead Teeth. *Proc. Roy. Soc. Med.*, 1949, **42**, 829.

Davis, R. Havard. Streptomycin in the Treatment of Tuberculous Sinuses: Review of 11 Cases. *Lancet*, 1949, ii, 982.

Doubleday, F. N. The Contributions of King's College, London, to the Science of Dentistry (C. E. Wallis Memorial Lecture). *Proc. Roy. Soc. Med.*, 1949, **42**, 783.

Graham, A. J. P., and Another. Effect of the head-down position on the Circulation in Hypotensive States. *Lancet*, 1949, ii, 941.

McCallum, R. I., and Others. Social Medicine. *Brit. J. Social Med.*, 1949, **3**, 77.

MacLean, K. S. Sleep and Insomnia. *Clin. J.*, 1949, **78**, 223.

APPOINTMENTS

C. S. Darke, M.D., M.R.C.P., has been appointed Consultant Physician, City General Hospital, and Physician, Thoracic Surgical Unit, Sheffield.

CHANGES OF ADDRESS

C. S. Darke, M.D., M.R.C.P., Consulting Rooms: 4, Claremont Place, Sheffield 10. (Tel. Sheffield 62463.)

BIRTHS

IRVINE.—On December 13th, 1949, in Victoria Ward, Guy's Hospital, to Peggy (née Walter), wife of Dr. R. E. Irvine—a second daughter (Deborah Mary).

JEANES.—On 30th November, 1949, at Woolwich Memorial Hospital, to Joyce (née Johnson), wife of Dr. C. W. L. Jeanes—a daughter (Rosemary Anne), a sister for David.

SELMANN.—On 10th December, 1949, at the Kimberley Maternity Home, South Africa, to Irene, wife of Harold M. Selmann, L.D.S.—a son.

MARRIAGES

BEALES—BURGESS.—On December 12th, 1949, at South Walton, Devon, Clifford Maxwell Beales, L.D.S., R.C.S. (Eng.), to Ruth Burgess, M.C.S.P.

DEATHS

BROMLEY.—On December 17th, 1949 (suddenly), Lancelot Bromley, M.B., B.Ch., M.Ch., F.R.C.S., Little Thatch, Seaford, Sussex.

EDS. {R.G. P.A.Z.